[redacted] STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15037

15840

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 518 Oxford Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): 3-#33337 — First: Robert — Middle: S. — Last: Adams

4. DATE OF DEATH: Month: 11 — Day: 4 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEP.

8. DATE OF BIRTH: Aug. 5, 1906

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: *******

11. BIRTHPLACE (County & State, or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Adam

14. MOTHER'S MAIDEN NAME: Essie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 248-09-2041

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Cardio Vascular Disease
DUE TO
(c):

4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): ---

20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. ---- 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.): ---

20f. (City or town) (County) (State): ---

21. I certify that (I) (this hospital) attended the deceased from ____, 19__, to 11/4, 19 66, that (I) (we) last saw the deceased alive on 11/4 19 66, and that death occurred at ____M, from causes and on the date stated above.

22a. SIGNATURE: Hildegard Heard Reisse M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11/4/66

22c. PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M.D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 11-14-66

23c. NAME OF CEMETERY OR CREMATORY: U.S. Natl. Mem. Cem. [illegible]

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: William Beese II — ADDRESS: 108 W. Washington St. Annapolis

25a. REC'D BY REGISTRAR — DATE: NOV 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 3 Per telephone call from funeral director 12/1/66 mh

15038

CERTIFICATE OF DEATH

15041

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 12 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): RURAL - Annapolis 021
d. STREET ADDRESS: Rt-5, Box-27-A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Osler Oslar — Middle Gordon — Lost ALLEN
4. DATE OF DEATH: Month November — Doy 15 — Year 19 66

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED XX — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8. DATE OF BIRTH: Jan. 21, 1918
9. AGE (In yeors last birthdoy): 48 yrs.
IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gen.Utility
10b. KIND OF BUSINESS OR INDUSTRY: *******
11. BIRTHPLACE (County & Stote, or foreign country): A.A.Co Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Acton Allen
14. MOTHER'S MAIDEN NAME: Goldie M.Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give wor or dotes of service) WW 11
16. SOCIAL SECURITY NO. 214-05-0860
17. INFORMANT: Lucille C.Allen — Address: Rt 5 Box 27A Annapolis, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
443X
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last.
DUE TO (b): Art. C.V. disease & hypertension — ?
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO XX

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (~~had~~) attended the deceased from 11/14/66, 19___, to 11/15, 19 66, that (I) (we) last saw the deceased alive on 11/14/66 19___, and that death occurred at 5:30 AM

22a. SIGNATURE: Maurice F Klawans — M.D. ATTENDING PHYS. XX — MED. DIRECTOR ☐ — STAFF PHYS. ☐
22b. DATE SIGNED: 11-16-66
22c. PHYSICIAN'S NAME (Type): MAURICE F. KLAWANS
22d. ADDRESS: 3150UTHGATE AV. Annapolis, md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/18/66
23c. NAME OF CEMETERY OR CREMATORY: Asbury Broadneck Church A.A.Co
23d. LOCATION (City or Town) (County) (Stote): Md

24. FUNERAL DIRECTOR: C.E.Hicks,111
ADDRESS: Annapolis, Maryland
25a. REC'D BY REGISTRAR DATE: NOV 23 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15039

CERTIFICATE OF DEATH

15042

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Severna Park
   c. LENGTH OF STAY IN 1b: 2 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Earleigh Heights Rd.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
   d. STREET ADDRESS: Earleigh Heights Rd.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: William — Middle: Nicholas — Last: Allender, ~~Sr.~~ Jr.

4. **DATE OF DEATH**: Month: 11 — Day: 2 — Year: 1966

5. SEX: male ~~xxxxxxx~~

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-29-1892

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Balto. City

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nicholas ~~xxxxxxxxxxx~~ Allender, ~~Sr.~~

14. MOTHER'S MAIDEN NAME: Clara A. Holland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give wer or detes of service)

16. SOCIAL SECURITY NO.: 212128135

17. INFORMANT: Mr. Howard C. Allender, Address: 1658 Myamby Rd. #4

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: few hours

DUE TO (b): Coronary occlusion

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerotic Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..... to ..... 19....., that (I) (we) last saw the deceased alive on ..... 19....., and that death occurred at 6:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Ray Smith M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: Nov. 7, 1966

22c. PHYSICIAN'S NAME (Type): RAY M. SMITH M.D. — 22d. ADDRESS: Severna Park Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 11/5/66. — 23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery — 23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Leonard J. Ruck, Inc. — ADDRESS: Baltimore, Md.

25a. REC'D BY REGISTRAR — DATE: NOV 7 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A1S (4)
20M 5-63

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15040 **CERTIFICATE OF DEATH** 15043

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEVERNA PARK
   c. LENGTH OF STAY IN 1b: 20 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rt 2 Box 659

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MD. — b. COUNTY: A. A.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park Rural
   d. STREET ADDRESS: Box 659, Rt 2. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Laura — Middle: Dorothy — Last: Armstrong

4. **DATE OF DEATH**: Month: 11-14-66 — Day — Year: 19

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 24 Jan 1885 — 9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: Home — 11. BIRTHPLACE (County & State, or foreign country): New Jersey — 12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Henry Rehahn — 14. MOTHER'S MAIDEN NAME: L. Spencer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.: 130 30 1347

17. INFORMANT — Address

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): A.C.V.D.
DUE TO (c): Heart Dis

4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1955, 19, to 1966, 19, that (I) (we) last saw the deceased alive on 11-16-66 19, and that death occurred at 10:50 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert R. Hahn M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Robert R. HAHN — 22d. ADDRESS: P.O. BOX 73 Severna Park

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 11/18/66 — 23c. NAME OF CEMETERY OR CREMATORY: Locust Com. — 23d. LOCATION (City, town or county) (State): Greene Co., N.Y.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert S. Barranco — ADDRESS: Severna Park, Md. — 25a. REC'D BY REGISTRAR DATE: NOV 17 1966 — 25b. REGISTRAR'S SIGNATURE: J Charles Judge

ROBERT S. BARRANCO

VR A1S (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15041

CERTIFICATE OF DEATH

15044

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL: Shady Side
d. STREET ADDRESS: Avalon Shores
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Harry — Middle Frank — Last BEINLICH
4. DATE OF DEATH: Month November — Day 22 — Year 19 66
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 21, 1895
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired U. S. Gov't.
10b. KIND OF BUSINESS OR INDUSTRY: Printing Office
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): WWI 6-21-1916 8-31-1921
16. SOCIAL SECURITY NO.: 4201
17. INFORMANT — Address: Mildred E. Beinlich — Same as Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular fibrillation & cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): Myocardial infarction — 3 days
DUE TO (c): Arteriosclerotic heart disease c coronary insufficiency — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (the ~~coroner~~) attended the deceased from Jan, 19 61, to Nov. 22, 19 66, thot (I) (we) lost sow the deceased alive on Nov. 22, 19 66, and that death occurred at 9:00 AM M, fram couses and on the date stoted above.

22a. SIGNATURE: Willard F. Smith M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/22/66
22c. PHYSICIAN'S NAME (Type): Willard F. Smith, M.D.
22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 25-1966
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cem.
23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR: Simmons Bros.
ADDRESS: Simmons Bros. 1661-Good Hope Rd SE Wash DC
25a. REC'D BY REGISTRAR — DATE: NOV 23 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15042

CERTIFICATE OF DEATH

15045

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edlesville
c. LENGTH OF STAY IN 1b: 70 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edlesville 021
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles — Middle Christian — Last Benning

4. DATE OF DEATH: Month Nov — Day 8 — Year 19 66

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11-15-88

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman

10b. KIND OF BUSINESS OR INDUSTRY: Fire Dept

11. BIRTHPLACE (County & State, or foreign country): Shadyside Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Carl Benning

14. MOTHER'S MAIDEN NAME: Fredricka Lutt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 213365654

17. INFORMANT: Elmer Benning — Address: Edlesville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b): Arteriosclerotic heart disease c — years
DUE TO (c): coronary insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute congestive heart failure + diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 19 60, to Nov. 8, 19 66, that (I) (we) last saw the deceased alive on Nov 7 19 66 and that death occurred at 3 4 M, from causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/8/66

22c. PHYSICIAN'S NAME (Type): Willard F. Smith MD

22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-11-66

23c. NAME OF CEMETERY OR CREMATORY: Walker

23d. LOCATION (City or Town) (County) (State): Edlesville AA Md

24. FUNERAL DIRECTOR — ADDRESS: Bernard Hardesty Edlesville Md

25a. REC'D BY REGISTRAR — DATE: NOV 22 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15043

CERTIFICATE OF DEATH

15046

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 hr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 02.1
d. STREET ADDRESS: 70 W. Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eric — Middle: — Last: BERNARD

4. DATE OF DEATH: Month: November — Day: 11 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 11, 1966

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: 1 — Min.: 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newborn

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Joseph Semebly

14. MOTHER'S MAIDEN NAME: Bonnie Ray Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Barbara Johnson Address: Anna Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): IMMATURITY — INTERVAL BETWEEN ONSET AND DEATH:
776X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) attended the deceased from Nov. 11, 1966, to Nov. 11, 19 66 that (I) saw last saw the deceased alive an Nov. 11, 19 66, and that death occurred at 7:10 P.M. from causes and an the date stated above.

22a. SIGNATURE: Charles B Hargrove M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: November 12, 1966

22c. PHYSICIAN'S NAME (Type): Charles B. Hargrove M. D.

22d. ADDRESS: Hahn Prof. Bldg., Severna Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-15-66

23c. NAME OF CEMETERY OR CREMATORY: Brewer Hell

23d. LOCATION (City or Town) (County) (State): Annapolis Md

24. FUNERAL DIRECTOR: William Reese — ADDRESS: Anna. Md

25a. RECD BY REGISTRAR DATE: NOV 15 1966

25b. REGISTRAR'S SIGNATURE: James Judge

6-23149

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15044

CERTIFICATE OF DEATH

15047

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
CROWNSVILLE MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CROWNSville STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS 021
d. STREET ADDRESS: BOX 47, RIVA Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK Middle Last BERWINKEL
4. DATE OF DEATH: Month 11 Day 13 Year 1966.
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-11-1886
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cabinetmaker (ret.)
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (County & State, or foreign country): HUNGARY
12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 212-54-9796
17. INFORMANT Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRO-VASCULAR ACCIDENT
DUE TO: ARTERIOSCLEROSIS.
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CHRONIC BRAIN SYNDROME SEC ARTERIOSCLEROSIS
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.): ----------
20c. TIME OF INJURY Manth, Day, Year: ----hour am---- p.m. 19
20d. INJURY OCCURRED While at work ☐ Nat While at work ☐
20e. PLACE OF INJURY (Hame, farm, factory, street, affice bldg., etc.)
20f. (City ar town) (County) (Stote)

21. I certify that (I) (this hospital) attended the deceased from 7-11-, 1966 to 11-13, 1966 that (I) (we) last saw the deceased alive on 11-13-1966 and that death occurred at 1055 M, fram causes and an the date stated abave.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 11/14/66
22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.
22d. ADDRESS: Crownsville State Hospital, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/17/66
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City or Town) (County) (Stote): Suitland Md.
24. FUNERAL DIRECTOR: Beverley E. Hopping Hopping Funeral Home
ADDRESS: Annapolis, Md. Beverley E. Hopping
25a. REC'D BY REGISTRAR DATE: NOV 16 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital ar attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15045

CERTIFICATE OF DEATH

15048

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE
   c. LENGTH OF STAY IN 1b: 10 YRS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6502 A N. CHARTER RD.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: ANNE ARUNOEL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE 021
   d. STREET ADDRESS: 6502 A CHARTER RD.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ETHEL — Middle — Last BOUNO

4. **DATE OF DEATH**: Month NOVEMBER — Day 22 — Year 19 66

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JULY 7, 1881

9. AGE (In years last birthday): 85 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE (RET)

10b. KIND OF BUSINESS OR INDUSTRY: OWNHOME

11. BIRTHPLACE (County & State, or foreign country): SCRANTON, PA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM BARNUM (OCSO)

14. MOTHER'S MAIDEN NAME: ELEANOR RANOOLPH (OCSO)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
   (If yes give war or dates of service): ////////

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS. BETTY RETHILL — Address: SAME AS # 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Osteogenic sarcoma — INTERVAL BETWEEN ONSET AND DEATH:
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): Carcinomatosis — 8 mo
   DUE TO
   (c): 1969

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Oct 29, 19 66, to Nov. 22, 19 66 that (I) (we) last saw the deceased alive on Nov. 22 19 66, and that death occurred at 9:00 M, from causes and on the date stated above.

22a. SIGNATURE: Robert DAbolins — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: NOV. 22, 1966

22c. PHYSICIAN'S NAME (Type): ROBERT OABOLINS MO

22d. ADDRESS: 400 CRAIN HIGHWAY NW GLEN BURNIE

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: NOV 25,1966

23c. NAME OF CEMETERY OR CREMATORY: MT. GREENWOOD CEMETERY

23d. LOCATION (City or Town) (County) (State): TRUCKSVILLE, PA.

24. FUNERAL DIRECTOR: R.V. SINGLETON — ADDRESS: GLEN BURNIE, MO.

25a. REC'D BY REGISTRAR DATE: NOV 23 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15046 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 15049

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY A.A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) A.A. General Hospt

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE MD. b. COUNTY A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHOREACRES
d. STREET ADDRESS ARNOLD, MD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: CHARLES Middle: F. Last: BRADFORD SR.

4. DATE OF DEATH Month: 11 Day: 2 Year: 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-4-1876

9. AGE (In years last birthday): 90 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dairy Products

10b. KIND OF BUSINESS OR INDUSTRY: DAIRY

11. BIRTHPLACE (State or foreign country): Balto. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Bradford

14. MOTHER'S MAIDEN NAME: Elizabeth Corns

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT Address: CHARLES F. BRADFORD JR. #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis generalized — INTERVAL BETWEEN ONSET AND DEATH: Sudden
4500
Conditions, if any, which gave risa to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE E.L. Winbrecht M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) E.L. Winbrecht.
Address (Street, city, town, or county)

22. DATE SIGNED 11/2/66.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE THEREOF 11-5-66

23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN

23d. LOCATION (City, town or county) GLEN BURNIE (State) MD.

24. FUNERAL DIRECTOR John M. Taylor & Sons ADDRESS Annapolis, Md.

25a. REC'D BY REGISTRAR DATE NOV 4 1966

25b. REGISTRAR'S SIGNATURE J. Charles Judge

VR A15ME (5) 5M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15103

CERTIFICATE OF DEATH

15103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — Crownsville State Hosp — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville St. Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Md. — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 21401
d. STREET ADDRESS: 28, Shaw St. Annapolis
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Brent — Middle: Mack — Last:
4. DATE OF DEATH: Month: 11 — Day: 5 — Year: 19 66
5. SEX: M
6. COLOR OR RACE: N
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2.22.13
9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): unknown
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown to us
14. MOTHER'S MAIDEN NAME: unknown to us

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Hospital secr B

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage.
DUE TO (b): Acute Alcoholic intoxication.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
3220
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ~~(I)~~ (this hospital) attended the deceased from 11/3/66, 19__ to 11/5/66, 19__, that ~~(I)~~ (we) last saw the deceased alive on 11/5/66 19__, and that death occurred at 2:15 ~~A~~ P.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/5/66
22c. PHYSICIAN'S NAME (Type): L. BENEDICT M.D.
22d. ADDRESS: Crownsville State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-9-66
23c. NAME OF CEMETERY OR CREMATORY: Chews Memorial
23d. LOCATION (City or Town) (County) (State): Owensville Md.

24. FUNERAL DIRECTOR: William Reese II — ADDRESS: Anna. Md.
25a. REC'D BY REGISTRAR DATE: NOV 14 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15047

CERTIFICATE OF DEATH

15050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Anundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 530 Harbor Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Aubrey — Middle: Stanton — Last: BROWN

4. DATE OF DEATH: Month: November — Day: 25 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 8, 1894

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET.

10b. KIND OF BUSINESS OR INDUSTRY: SALESMAN

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: J. THOMAS BROWN

14. MOTHER'S MAIDEN NAME: HONORA EATON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: ANNA MAYRETTA BROWN — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ac. Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(his/her/their)~~ attended the deceased from Nov 22, 1966, to Nov. 25, 1966, that (I) ~~(he/she/they)~~ last saw the deceased alive on Nov 25, 1966, and that death occurred at 10:48 pm M, from causes and on the date stated above.

22a. SIGNATURE: Monnie K Klawans M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/27/66

22c. PHYSICIAN'S NAME (Type): M.F. KLAWANS

22d. ADDRESS: 31 South Main St.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 11-29-66

23c. NAME OF CEMETERY OR CREMATORY: OLD ST. PAULS CHURCH

23d. LOCATION (City or Town) (County) (State): CHESTERTOWN KENT MD.

24. FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: NOV 29 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15048 (M) 15051

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: A A Co — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ANNE ARUNDEL GEN. HOSPT.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MD
   b. COUNTY: A.A.Co. (Rural)
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EDGEWATER (RURAL ANNAPOLIS)
   d. STREET ADDRESS: RT #1 BOX 370
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First CHARLES Middle CLINTON Last BROWN

4. DATE OF DEATH: Month NOV Day 5 Year 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 7 1893

9. AGE (In years last birthday): 73 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. INSURANCE AGT

10b. KIND OF BUSINESS OR INDUSTRY: INSURANCE

11. BIRTHPLACE (County & State, or foreign country): SANDYVILLE W. VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES L. BROWN

14. MOTHER'S MAIDEN NAME: CORA VIRGINIA BOSWORTH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: CHELLA PEARL BROWN Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: Minutes
   DUE TO
   (b): Coronary heart disease — 6 mos
   DUE TO
   (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1 1966 to Nov 5 1966 that (I) (we) last saw the deceased alive on Nov 5 1966, and that death occurred at 7:30 M, from causes and on the date stated above.

22a. SIGNATURE: Gerard Church — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/7/66

22c. PHYSICIAN'S NAME (Type): GERARD CHURCH

22d. ADDRESS: 121 CATHERINE ST ANNAPOLIS MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 11-8-1966

23c. NAME OF CEMETERY OR CREMATORY: MAYO MEM. CEM.

23d. LOCATION (City or Town) (County) (State): MAYO A.A.Co MD

24. FUNERAL DIRECTOR: JOHN M. TAYLOR SONS ADDRESS: ANNAPOLIS MD

25a. REC'D BY REGISTRAR DATE: NOV 10 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15049

CERTIFICATE OF DEATH

15052

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G MEADE
c. LENGTH OF STAY IN 1b: 1 day

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ODENTON 02.1
d. STREET ADDRESS: 461 Oakton Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): KIMBROUGH ARMY HOSPITAL

3. NAME OF DECEASED (Type or print): First HENRY Middle R Lost BURK, Sr.

4. DATE OF DEATH: Month NOVEMBER Doy 28 Year 19 66

5. SEX: MALE
6. COLOR OR RACE: CAU
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10 JUN 1905
9. AGE (In yeors lost birthday): 61 yrs.
IF UNDER 1 YEAR: Months Doys
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (Army) Ret.
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & Stote, or foreign country): TENNESSEE
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ISSAC JOSH BURK
14. MOTHER'S MAIDEN NAME: DENICE FALIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give wor or dates of service): not available
16. SOCIAL SECURITY NO.: 216-18-6593
17. INFORMANT: Hazel M. Burk Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Embolization right atrium acute myocardial infarction (massive)
DUE TO
(b):
DUE TO
(c):
Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 27 Nov, 1966, to 28 Nov, 1966, that (I) (we) last saw the deceased alive on 8:00PM 28 Nov 1966, and that death occurred at 8:20PM, from causes and on the date stated above.

22a. SIGNATURE: Benzoin Benatar M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 28 Nov 66
22c. PHYSICIAN'S NAME (Type): BENZOIN BENATAR, CAPT, MC
22d. ADDRESS: KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 2/1966
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Park, Glen Burnie, Md.
23d. LOCATION (City or Town) (County) (State)

24. FUNERAL DIRECTOR ADDRESS: SINGLETON FUNERAL HOME GLEN BURNIE, MARYLAND
25a. REC'D BY REGISTRAR DATE: NOV 30 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15050

CERTIFICATE OF DEATH

15053

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): (Dead on arrival) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riva
d. STREET ADDRESS: XXXXX Sylvan Shores
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James; Middle G.; Last BURKE
4. DATE OF DEATH: Month November; Day 15; Year 19 66
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 26, 1903
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cartography Eng.(ret)
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't
11. BIRTHPLACE (County & State, or foreign country): Pittston, Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Edward J. Burke
14. MOTHER'S MAIDEN NAME: Catherine Costello

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): no
16. SOCIAL SECURITY NO.: 579-16-2930
17. INFORMANT Address: Mrs.Dorothea S. Burke - same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b): Essential Hypertension — Unknown
DUE TO (c):
Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse lost.
331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 5/15, 1963, to 10/20, 1966, that (I) ~~(we)~~ last saw the deceased alive on 10/20 1966, and that death occurred at 12:50 P M, from causes and on the date stated above.

22a. SIGNATURE: Richard I. Hochman M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/15/66
22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, M.D.
22d. ADDRESS: 59 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/18/66
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
23d. LOCATION (City or Town) (County) (Stote): Annapolis A.A. Md.

24. FUNERAL DIRECTOR: Beverley E. Hopping, Hopping Funeral Home
ADDRESS: Beverley E. Hopping, Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: NOV 21 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15051 — 15054

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE
   c. LENGTH OF STAY IN 1b: 2 HOURS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NORTH ARUNDEL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEVERN 02-1
   d. STREET ADDRESS: 2 VIRGINIA AVE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: GEORGE — Middle: — Last: BUTLER

4. **DATE OF DEATH**: Month: NOVEMBER — Day: 24 — Year: 19 66

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 1, 1892

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MINISTER

10b. KIND OF BUSINESS OR INDUSTRY: CHURCH

11. BIRTHPLACE (County & State, or foreign country): NEW FOUNDLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: EDWARD BUTLER

14. MOTHER'S MAIDEN NAME: SUSAN LITTLEJOHN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address: MRS. BEULAH B. BUTLER (same as #2)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure
420.1
DUE TO
(b): Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Coronary - heart disease

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11-24, 19 66, to 11-24, 19 66, that (I) (we) last saw the deceased alive on 11-24 19 66, and that death occurred at 11:40 A.M., from causes and on the date stated above.

22a. SIGNATURE: Ernest A Leipold — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-24-66

22c. PHYSICIAN'S NAME (Type): ERNEST A. LEIPOLD

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 28, 1966

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

23d. LOCATION (City or Town) (County) (State): Colmar Manor Pr. Geo. Co. Md.

24. FUNERAL DIRECTOR: J. Arthur Walters — ADDRESS: 754 Carroll St. N.W. Washington, D.C.

25a. REC'D BY REGISTRAR DATE: NOV 28 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15052

CERTIFICATE OF DEATH

15055

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: A. ARUNDEL — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: A. Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum 021
c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Aaundel Hospital	d. STREET ADDRESS: 427 Greenwood Rd — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: BARBARA	Middle: M.	Last: CALLAHAN	4. DATE OF DEATH	Month: November	Day: 27	Year: 1966	
5. SEX: F	6. COLOR OR RACE: W	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 1-17-1905	9. AGE (In years last birthday): 61 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Henry Quentin		14. MOTHER'S MAIDEN NAME: Lessner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)	16. SOCIAL SECURITY NO.: 215-14-5063	17. INFORMANT: Daniel R. Callahan	Address: As Above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO: HASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): 443X
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11-26- 1966 to 11-27- 1966, that (I) (we) last saw the deceased alive on 11-27- 1966, and that death occurred at 8:40 A.M., from causes and on the date stated above.

22a. SIGNATURE: Ignas Saulynas	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: 11-27-1966	
22c. PHYSICIAN'S NAME (Type): IGNAS SAULYNAS	22d. ADDRESS: 319 Old Annapolis Rd Jessup Md		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 12/1/66	23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Memorial	23d. LOCATION (City or Town): Howard County, Md.	(County) (State)
24. FUNERAL DIRECTOR: Raymond C. Fink	ADDRESS: Glen Burnie, Md.	25a. REC'D BY REGISTRAR DATE NOV 30 1966	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15053 **CERTIFICATE OF DEATH** 15056

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: 10 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 203 Summit Ave., Marley Park

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   d. STREET ADDRESS: 203 Summit Ave., Marley Park
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Jennie — Middle: M. — Last: Carroll

4. **DATE OF DEATH**: Month: Nov. — Day: 26, — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 24 April 1885

9. AGE (In years last birthday): 81 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Cadden

14. MOTHER'S MAIDEN NAME: Marget Cassidy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 216-07-7404

17. INFORMANT: Mr. Joseph Lang, 20 W. Furnace Branch Road, Address: Glen Burnie, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

443X

DUE TO (b): Hypertensive cardiovascular disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Yeer 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug. 17, 1962 to Nov. 26, 1966, that (I) (we) last saw the deceased alive on Nov. 26 1966, and that death occurred at ..... M, from the causes and on the date stated above.

22a. SIGNATURE: Edmond I. Moushabek M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 28 Nov. 1966

22c. PHYSICIAN'S NAME (Type): Edmond I. Moushabek, M. D.

22d. ADDRESS: 510 Marley Station Road, Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 29 Nov. 1966

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Kirkley Funeral Home,

ADDRESS: Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: NOV 30 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15054 — 15057

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
1SM 7-62

1. PLACE OF DEATH — a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A. A. General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — e. STATE: Md. — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 77 Pleasant St. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: H — Last: Carter

4. DATE OF DEATH: Month: 11 — Day: 14 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: Col

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-15-1897

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Hampton Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Lucy Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 218-01-8224

17. INFORMANT — Address: Annie V. Howard, Anna Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Hypertensive Cardio Vascular — INTERVAL BETWEEN ONSET AND DEATH

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Disease — 1 year ago

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from November, 1966, to 11-14-, 19 66 that (I) (we) last saw the deceased alive on 11-14- 1966, and that death occurred at 5A M, from the causes and on the date stated above.

22a. SIGNATURE: R. L. Richardson M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: Nov. 14, 66

22c. PHYSICIAN'S NAME (Type): R. L. Richardson, M.D. — 22d. ADDRESS: 110 Clay St., Annapolis, Md., 21401

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 11-17-66 — 23c. NAME OF CEMETERY OR CREMATORY: Pine Lawn — 23d. LOCATION (City, town or county) (State): Annapolis Md

24. FUNERAL DIRECTOR'S SIGNATURE: William Reese — ADDRESS: Anna Md — 25c. REC'D BY REGISTRAR DATE: NOV 15 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15055

CERTIFICATE OF DEATH

15058

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d. STREET ADDRESS: P.O. Box 111
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Edward — Last: CHEEK

4. DATE OF DEATH: Month: November — Day: 9, — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 20, 1904

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELECTRICIAN

10b. KIND OF BUSINESS OR INDUSTRY: R.R. Co.

11. BIRTHPLACE (County & State, or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JAMES H. CHEEK

14. MOTHER'S MAIDEN NAME: IRENE M. WUNDER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: FLORA M. CHEEK — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): Generalized (metastatic) carcinomatosis — 2 years
DUE TO
(c): Adenocarcinoma of prostate gland — 3 years (?)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

177X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(knew)~~ attended the deceased from July, 1965, to Nov. 9, 1966, that (I) (we) last saw the deceased alive an Nov. 9, 1966, and that death occurred at 11:10 am M, from causes and on the date stated above.

22a. SIGNATURE: Charles W. Kinzer M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Nov. 10, 1966

22c. PHYSICIAN'S NAME (Type): Charles W. Kinzer, M. D.

22d. ADDRESS: South River Medical Center Edgewater, Maryland (21037)

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-12-66

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

23d. LOCATION (City or Town) (County) (State): Suitland MD.

24. FUNERAL DIRECTOR: John M. Ley & Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: NOV 15 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15056

CERTIFICATE OF DEATH

15059

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 6408 Fairdel Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Jens — Middle: Martin — Last: Christensen

4. **DATE OF DEATH**: Month: Nov. — Day: 6, — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 30, 1886

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rigger

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Denmark

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Don't know

14. MOTHER'S MAIDEN NAME: Don't know

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Anna B. Dahlgreen 6408 Fairdel Ave.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arterio-sclerotic Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 9 yrs

4221

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 9-22- 1957 to 11-5- 19.66 that (I) (~~we~~) last saw the deceased alive on 11-5- 1966., and that death occurred at 9 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Milton C. Lang M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Milton C. Lang

22d. ADDRESS: 2117 Belair Road

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/10/66

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ullrich Funeral Home 4210 Belair Road

25a. REC'D BY REGISTRAR — DATE: NOV 9 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1 (M)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15057

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15060

1. **PLACE OF DEATH**
   a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Brooklyn~~ Glen Burnie
   c. LENGTH OF STAY IN 1b
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): O.O.A. North Arundel Hosp

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MD. — b. COUNTY: A.A.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 25 — 02-1
   d. STREET ADDRESS: 1863 Allentown Rd
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Milton — Middle: F — Last: Collier

4. **DATE OF DEATH**: Month: 11 — Day: 27 — Year: 19 66

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-14-1909

9. AGE (In years last birthday): 57 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mech.

10b. KIND OF BUSINESS OR INDUSTRY: Bd. of Trade

11. BIRTHPLACE (State or foreign country): Miss

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Herman

14. MOTHER'S MAIDEN NAME: Lillian Summers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes.

16. SOCIAL SECURITY NO.

17. INFORMANT: Family - Same — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: Later
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): 1992
   DUE TO
   (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Lindwall M.D.

EXAMINER'S NAME (Type): E. Lindwall

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

22. DATE SIGNED: 11/27/66.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/25/66

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven

23d. LOCATION (City or Town) (County) (State): Balto.

24. FUNERAL DIRECTOR: Kelly - 130 E Fort Ave. — ADDRESS

25a. REC'D BY REGISTRAR DATE: NOV 23 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15058

CERTIFICATE OF DEATH

15061

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 8 Hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Trappe
d. STREET ADDRESS: 550 Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marie — Middle: E. — Last: Cowan
4. DATE OF DEATH: Month: Nov. — Doy: 28, — Year: 1966
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 20, 1883
9. AGE (In yeors lost birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Abbeville, S. Car.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Preston A. Cheatham
14. MOTHER'S MAIDEN NAME: Minnie Brooks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs. Sahah Rambo, same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from 11-23, 1966, to 11-28, 1966, that (I) ~~(we)~~ last saw the deceased alive on 11-28 1966, and thot death occurred at 2:35 P.M., from causes and on the date stated above.

22a. SIGNATURE: Wayne B Tate M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/28/66
22c. PHYSICIAN'S NAME (Type): Wayne B. Tate, M. D.
22d. ADDRESS: 108 Central Ave., Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 30 Nov. 1966
23c. NAME OF CEMETERY OR CREMATORY: Long Cane Cemetery
23d. LOCATION (City or Town) (County) (State): Abbeville, South Carolina

24. FUNERAL DIRECTOR — ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE: NOV 30 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 15059

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15062

1. NAME OF DECEASED (Type or Print): Helen Regina Cremer
2. DATE AND HOUR OF DEATH: 11/25/66 — 6⁰⁰ A. M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND: ANNE ARUNDEL COUNTY
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1103 Broadview Blvd 00 Glen Burnie Md
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: Md. B. COUNTY: York
   C. CITY OR TOWN (If outside city limits, write RURAL and give township): Hanover 75-3
   D. STREET ADDRESS (If rural, give location): 202 Stock Street
5. SEX: F. 6. RACE: W. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M.
8. DATE OF BIRTH: 4/27/1914 9. AGE (In years last birthday): 52 — If Under 1 Yr. Months/Days — If Under 24 Hrs. Hours/Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Campbell Co
10B. KIND OF BUSINESS OR INDUSTRY: dress Mfg.
11. BIRTHPLACE (State or foreign country): Adams Co Pa
12. CITIZEN OF WHAT COUNTRY?: U S A
13. FATHER'S NAME: Frank Kimple
14. MOTHER'S MAIDEN NAME: Kincola Stauffer
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 185-34-8807
17. INFORMANT: Mrs Richard Kagan, 1103 Broadview Blvd — ADDRESS: Glen Burnie Md

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		
	(A) DUE TO: Congestive Heart Failure	sudden
170X ANTECEDENT CAUSES	(B) DUE TO: Generalized Carcinomatosis	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(C) Primary Breast Carcinoma	
II — OTHER ~~SIGNIFICANT~~ CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	—	—

22. I certify that (I) (~~this hospital~~) attended the deceased from 11/20 1966 to 11/25 1966 that (I) (we) last saw the deceased alive on 11/25 1966 and that in(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: James N. Frederick M.D. — Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 11/25/66
23C. PHYSICIAN'S NAME (Type): James N. Frederick M.D.
23D. ADDRESS: 1311 Francis Ave Baltimore, Md. 21227
24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/28/66
24C. NAME of CEMETERY or CREMATORY: M.P. Church
24D. LOCATION (City, town, or county) (State): Hanover Pa York Co
25A. DATE REC'D BY HEALTH DEPT.: NOV 30 1966
25B. NAME OF REGISTRAR: Charles Judge
25C. FUNERAL DIRECTOR: Wm. V. Keagy Inc. — ADDRESS: 269 Frederick St Hanover

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2

VR A15 (4
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15060

CERTIFICATE OF DEATH

15063

1. **PLACE OF DEATH**
   a. COUNTY: A. A. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A. A. General

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Md.
   b. COUNTY: A. A.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 02.1
   d. STREET ADDRESS: 52 Shaw
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Henry; Middle: Crocker; Last:
4. **DATE OF DEATH**: Month: 11 — Day: 11 — Year: 1966
5. SEX: Male
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-15-1891
9. AGE (In years last birthday): 75 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): North Carolina U.S.A.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Tom Crocker
14. MOTHER'S MAIDEN NAME: Lisa Crocker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary E. Tinsley — Address: Anna Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH:
   DUE TO (b):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4330
   DUE TO (c):
   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).
   19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5-8-66, 19..., to 11-11-66, 19..., that (I) (we) last saw the deceased alive on 11-10-66 19..., and that death occured at 6:45 M, from the causes and on the date stated above.

22a. SIGNATURE: A. T. Cale M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): A T ALLEN
22d. ADDRESS: 61 Cathedral St

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-15-66
23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
23d. LOCATION (City, town or county) (State): Annapolis Md

24. FUNERAL DIRECTOR'S SIGNATURE: William Reese — ADDRESS: Anna. Md.
25a. REC'D BY REGISTRAR DATE: NOV 15 1966
25b. REGISTRAR'S SIGNATURE: Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1 (M)

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15061

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15064

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): A.A. GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS 021
d. STREET ADDRESS: 203 LOCKWOOD COURT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Kenneth — Middle R. — Last Deale

4. DATE OF DEATH: Month NOV — Day 10 — Year 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT 9, 1903

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTING CONTRACTOR

10b. KIND OF BUSINESS OR INDUSTRY: PAINTING

11. BIRTHPLACE (State or foreign country): DEALE MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: PEYTON A. DEALE

14. MOTHER'S MAIDEN NAME: GRACE OLIVE PRICE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES
(If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.:

17. INFORMANT: DOLORES C. DEALE — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac disease — INTERVAL BETWEEN ONSET AND DEATH: Sudden
4344
Conditions, if any, which gave rise to immediate ceuse (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 11-10-66

EXAMINER'S NAME (Type): E. LINHARDT.
Address (Street, city, town, or county):

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11-13-1966
23c. NAME OF CEMETERY OR CREMATORY: ST. MARY'S CEM.
23d. LOCATION (City, town or county): ANNAPOLIS (State): MD.

24. FUNERAL DIRECTOR: JOHN M. TAYLOR SONS — ADDRESS: ANNAPOLIS MD

25a. REC'D BY REGISTRAR DATE: NOV 15 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A1SME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15062 15065

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): North Arundel General

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If dutside corporate limits, write RURAL and give nearest town): Elkridge 021
d. STREET ADDRESS: Box 126 B. Ridge Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harry Middle W. Last Diffendall
4. DATE OF DEATH: Month November Day 15 Year 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 12, 1892
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator
10b. KIND OF BUSINESS OR INDUSTRY: Glass House
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Wilbert Diffendall
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wilbert T. Diffendall Address: Box 126 B Ridge Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Arteriosclerotic CVRD — duration 15-20 yr.
DUE TO (c): Diabetes Mellitus- controlled — 8yr +or-
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from ----- , 1950 , to 11/15 , 1966 that (I) (we) last saw the deceased alive on 11/12 1966 , and that death occurred at 12 noon from the causes and on the date stated above.

22a. SIGNATURE: R. V. ~~Rangle~~ M.D. M.O. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/16/66
22c. PHYSICIAN'S NAME (Type): R.V. Rangle
22d. ADDRESS: 2938 St. Paul St.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/18/66
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
23d. LOCATION (City, town or county) (State): Baltimore Maryland

24. FUNERAL DIRECTOR: Ambrose Inc. ADDRESS: 1328 Sulphur Spg Rd.
25a. REC'D BY REGISTRAR DATE: NOV 21 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 2DM 1/65

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15063

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15066

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress): North Arundel General Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town): Pasadena
   d. STREET ADDRESS: Rt. 2, Box 21
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First EDWARD — Middle W. — Lost DUVALL

4. DATE OF DEATH: Month 11 — Day 11 — Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 28 Feb. 1903

9. AGE (In yeors lost birthday): 63 yrs.

IF UNDER 1 YEAR: Months — Days

IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Anne Arundel Co., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard I. Duvall

14. MOTHER'S MAIDEN NAME: Mary E. Whittington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mr. Ernest Duvall, Severna Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Gunshot Wound of Head — INTERVAL BETWEEN ONSET AND DEATH
   DUE TO
   Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
   (b):
   DUE TO
   (c):

   976 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): Shot self in head

20c. TIME OF INJURY Month, Doy, Yeor: Hour o.m. AM p.m. 11/11 19 66

20d. INJURY OCCURRED While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.): tavern

20f. (City or town) (County) (State): Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
DEPUTY MEDICAL EXAMINER [ ]

Address (Street, city, town, or county):

22. DATE SIGNED: 11/12/66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 15 Nov. 1966

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Baltimore 25, Md.

24. FUNERAL DIRECTOR — ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: NOV 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15064

CERTIFICATE OF DEATH

15067

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspitol, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town): Severna Park 02.1
d. STREET ADDRESS: Box 37 Rt. 2, Old Annapolis RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: NMN — Lost: EVANS
4. DATE OF DEATH: Month: November — Day: 5 — Year: 1966
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 1, 1901
9. AGE (In yeors last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance
10b. KIND OF BUSINESS OR INDUSTRY: *****
11. BIRTHPLACE (Caunty & State, ar foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Luther Evans
14. MOTHER'S MAIDEN NAME: Martha Evans

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give wor or dotes of service): ***
16. SOCIAL SECURITY NO.: 217-05-5107
17. INFORMANT: Elizabeth H. Evans — Address: Rt2 Box 37 Serverna Pk, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bleeding Peptic ulcer — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b):
Conditians, if ony, which gave rise to immediate couse (a), stating the underlying cause lost. DUE TO (c):
5400

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Haur o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Hame, farm, factary, street, affice bldg., etc.)
20f. (City ar tawn) (Caunty) (Stote)

21. I certify that (I) (this haspital) attended the deceased from 9-26-66, 19___, to 11-5-66, 19___, that (I) (we) last saw the deceased alive an 11-5-66 19___, and that death accurred at 4:30 P.M. from causes and an the date stated abave.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-7-66
22c. PHYSICIAN'S NAME (Type): A T ALLEN
22d. ADDRESS: 6 [illegible]

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/9/66
23c. NAME OF CEMETERY OR CREMATORY: Town Neck Church
23d. LOCATION (City or Town) (Caunty) (State): Anne Arundel Md

24. FUNERAL DIRECTOR: C.E.Hicks,III — ADDRESS: Annapolis, Maryland
25a. REC'D. BY REGISTRAR DATE: NOV 14 1966
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar remaval, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

15067

15067

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15065

CERTIFICATE OF DEATH

15068

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A. A. General

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 710 [illegible] St. Eastport
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mollie — Middle: — Last: Evans

4. DATE OF DEATH: Month: 11 — Day: 24 — Year: 1966

5. SEX: Female — 6. COLOR OR RACE: Col. — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 7-30-1929 — 9. AGE (In years last birthday): 37 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Byrd
14. MOTHER'S MAIDEN NAME: Hattie Parker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wm. Evans 710 [illegible] St. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest due to or toxic shock & — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): acute pyelonephritis w/ obstructed ureter — 624X
DUE TO (c): bilateral tubo-ovarian abscess (pyosalpinx) & extensive pelvic adhesions & intestinal bowel — several yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/11, 1966, to 11/24, 1966, that (I) (we) last saw the deceased alive on 11/24 1966, and that death occurred at 4:30 P M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-28-1966
23c. NAME OF CEMETERY OR CREMATORY: Adams
23d. LOCATION (City or Town) (County) (State): Lothian Md.

24. FUNERAL DIRECTOR: William Reese — ADDRESS: Lothian Md.
25a. REC'D BY REGISTRAR DATE: NOV 25 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15066

CERTIFICATE OF DEATH

16523

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G. MEADE
c. LENGTH OF STAY IN 1b: 51 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G. MEADE
d. STREET ADDRESS: 7334-A KELLY LOOP
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PEGGIE — Middle JOYCE ADAMS — Last EVANS

4. DATE OF DEATH: Month NOVEMBER — Day 30 — Year 19 66

5. SEX: FEMALE
6. COLOR OR RACE: CAU
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1 DEC 1935
9. AGE (In years last birthday): 30 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Selma Dallas, Alabama
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Emmett L. Adams
14. MOTHER'S MAIDEN NAME: Lorena L. Wheeler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): N/A
16. SOCIAL SECURITY NO.: 418-42-0824
17. INFORMANT: William Evans, 7334-A Kelly Loop — Address: Ft Geo G.Meade, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): METASTATIC DISEASE TO BRAIN — INTERVAL BETWEEN ONSET AND DEATH: 1 YEAR
DUE TO (b): MALIGNANT MELANOMA — 18 MONTHS
DUE TO (c): BRONCHO PNEUMONIA, CHRONIC PYELONEPHRITIS
190.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 8 Sept, 1966, to 30 Nov, 1966, that ☒ (we) last saw the deceased alive on 30 Nov 1966, and that death occurred at 4:20 P.M., from causes and on the date stated above.

22a. SIGNATURE: Carl S Rosen — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 30 Nov 66
22c. PHYSICIAN'S NAME (Type): CARL S. ROSEN, CPT, MC
22d. ADDRESS: KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: December 5, 1966
23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL CEM
23d. LOCATION (City or Town) (County) (State): ARLINGTON, VIRGINIA

24. FUNERAL DIRECTOR — ADDRESS: Harold S. Wade, Laurel, Md.
25a. REC'D BY REGISTRAR — DATE: DEC 12 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit (if) please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15067

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16524

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 3mos. 21days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 613 E. Baltimore Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): #32865 — First: Andrew — Middle: — Last: Fanny

4. **DATE OF DEATH**: Month: 11 — Day: 24 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: March 4, 1911

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stock Clerk

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Norfolk, Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Benjamin Fanny

14. MOTHER'S MAIDEN NAME: Goodman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 225-28-8897

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Alcoholic Intoxication — INTERVAL BETWEEN ONSET AND DEATH: One week
DUE TO
(b): Chronic Alcoholism — Years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 322.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ----------19--

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------

20f. (City or town) (County) (State): ----------

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Elmer G. Linhardt M.D.

EXAMINER'S NAME (Type): Dr. Elmer G. Linhardt, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: 11-27-66.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal — 23b. DATE THEREOF: 12/21/66 — 23c. NAME OF CEMETERY OR CREMATORY: UNIV. Md — 23d. LOCATION (City or Town): Balt. Md. — (County) (State)

24. FUNERAL DIRECTOR: William Reese II — ADDRESS: 108 W. Washington St. Annapolis, Maryland

25a. REC'D BY REGISTRAR — DATE: DEC 22 1966

25b. REGISTRAR'S SIGNATURE: Charles Yingst

VR A15ME (6) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15068 — 15069

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b: 4 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
   d. STREET ADDRESS: Rt. 1, Box 74B
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Clara — Middle: Hazel — Last: FENNER

4. **DATE OF DEATH**: Month: November — Day: 12 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 20, 1918

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical Wk Printing Co

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Frank Reinsch

14. MOTHER'S MAIDEN NAME: Catherine Weaver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-55-7447

17. **INFORMANT**: George L. Fenner — Address: Colum

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cervix Site of Cx — Hysterectomy —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) attended the deceased from _____, 19____, to _____, 19____, that (I) last saw the deceased alive on _____ 19____, and that death occurred at 3:50 A.M. from causes and on the date stated above.

22a. SIGNATURE: William F Krone M.D. — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): William F. Krone, M.D.

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/15/66

23c. NAME OF CEMETERY OR CREMATORY: Druid Ridge

23d. LOCATION (City or Town) (County) (State): Pikesville Balto, Md

24. FUNERAL DIRECTOR: Robert L. Barranco — ADDRESS: Severna Pk. Md — ROBERTS BARRANCO

25a. REC'D BY REGISTRAR DATE: NOV 17 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15069

CERTIFICATE OF DEATH

15070

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the buriol-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremation, or removal, and if buryevent, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL — Crownsville State Hosp — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest tawn)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) Crownsville State Hosp

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE 3507 Maryland Belair Road
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest tawn) Baltimore. 30.4
d. STREET ADDRESS 518 N. Decker Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First VALENTINE Middle Lost Fischer
4. DATE OF DEATH 8:25 P.M. Month 11 Doy 4 Year 1966
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 7. 14. 11
9. AGE (In yeors lost birthday) 55 yrs.
IF UNDER 1 YEAR Months Doys
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Carpenter
11. BIRTHPLACE (County & Stote, or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME John C. Fischer
14. MOTHER'S MAIDEN NAME Bernardine (Fischer) Wilgen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO. 217-29-5052
17. INFORMANT Address Andrew H. Fischer 3507 Belair Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) Cerebral Embo.
DUE TO (b) Hypertensive Encephalopathy.
DUE TO (c)
Conditions, if any, which gove rise to immediote couse (o), stoting the underlying couse lost. 334X ?
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (this haspital) attended the deceased from 8/8/66, 19__ to 11/4/66, 19__, that (I) (we) last saw the deceased alive an 11/4/66 19__, and that death accurred at 8:25 P.M, from causes and an the date stated abave.

22o. SIGNATURE
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED 11/5/66
22c. PHYSICIAN'S NAME (Type) L. BENEDICT M.D.
22d. ADDRESS Crownsville State Hospital

23o. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 11-8-66
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery
23d. LOCATION (City or Town) (County) (Stote) Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc Baltimore, Md.
25o. REC'D BY REGISTRAR DATE NOV 9 1966
25b. REGISTRAR'S SIGNATURE J. Charles Jyage

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15070 15071

1. PLACE OF DEATH
a. COUNTY A.A. Co MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A.A. Co. Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md b. COUNTY A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold Md 021
d. STREET ADDRESS Rt 3 Box 302 Shore Acres
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First JAMES Middle F. Last FITZSIMMONS
4. DATE OF DEATH Month 11 Day 20 Year 1966
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 10-9-89
9. AGE (In years last birthday) 77 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR
10b. KIND OF BUSINESS OR INDUSTRY GAS + ELECT. Co
11. BIRTHPLACE (County & State, or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James J. Fitzsimmons
14. MOTHER'S MAIDEN NAME Bridgett Finerty
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Edith Fitzsimmons Address Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 4 hours
4201
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b) Coronary arteriosclerotic heart disease — 1 year
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) none
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 12/19, 1956, to 11/20, 1966, that (I) (~~he~~) last saw the deceased alive on 11/7 1966, and that death occurred at 11 P.M, from the causes and on the date stated above.

22a. SIGNATURE R.M. McLaughlin M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 11/21/66
22c. PHYSICIAN'S NAME (Type) R.M. McLaughlin
22d. ADDRESS 3708 Mountain Road Pasadena, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 11/23/66
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem
23d. LOCATION (City, town or county) (State) Glen Burnie Md
24. FUNERAL DIRECTOR Robert J. Barranco ADDRESS Severna Pk. Md
25a. REC'D BY REGISTRAR DATE NOV 23 1966
25b. REGISTRAR'S SIGNATURE J. Charles Judge

ROBERT J. BARRANCO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15071 Item 8 Film G382 11/14/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15072

1 FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: A.A.Co. — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town):
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): A.H. General Hosp.

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: WASH. D.C. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town):
d. STREET ADDRESS: 2533 Waterside Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Kitty — Middle: B. — Lost: Frank
4. DATE OF DEATH: Month: 11 — Doy: — Year: 19 66

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 16, 1922
9. AGE (In yeors last birthday): 44 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Edwin Blair
14. MOTHER'S MAIDEN NAME: Lucy Rachel Stiegers.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes give war or dotes of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Robert B. Frank - See Item #2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Bronchopneumonia
DUE TO (b):
DUE TO (c):
Conditions, if ony, which gave rise to immediate couse (o), stoting the underlying couse lost.
INTERVAL BETWEEN ONSET AND DEATH: 2 hours.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): auto accident - Rt. 50 —
20c. TIME OF INJURY Month, Doy, Yeor — Hour a.m. / p.m.: 11/2 1966
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.): highway
20f. (City or town) (County) (State): A.A.Co. Md.

21. I certify thot I took charge of the remoins described obove, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion deoth resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): E. Linhardt.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 11-2-66

23o. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 11-5-1966
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City or Town) (County) (State): Suitland, Md.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc.
ADDRESS: 5130 Wisc. Ave. N.W. Wash. D.C.
25o. REC'D BY REGISTRAR DATE: NOV 7 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15072 — 15073

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessory, pleose execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funerol director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used os o buriol-transit permit. File pages 1 and 2 with the Stote Deportment of Health or its designoted agent, prior to buriol, cremation, or removol, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Anne Arundal — MARYLAND
   b. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: 1 hr
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): D.O.A.-North Arundel-Hospital
2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) — a. STATE: Maryland — b. COUNTY: A. Arundal
   c. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town): Pasadena-MD
   d. STREET ADDRESS: Rt 1-Box 207A-Gibson Rd
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First Vernon — Middle K — Lost Garrett
4. DATE OF DEATH: Month 11 — Doy 23 — Year 1966
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/20/1897
9. AGE (In years lost birthdoy): 69 yrs.
   IF UNDER 1 YEAR: Months — Doys
   IF UNDER 24 HRS.: Hours — Min.
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance Agent
10b. KIND OF BUSINESS OR INDUSTRY: Insurance
11. BIRTHPLACE (State or foreign country): N.C
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John T. Garrett
14. MOTHER'S MAIDEN NAME: Sarah Garrett
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dotes of service)
16. SOCIAL SECURITY NO.: 214-03-3008
17. INFORMANT: Mrs. Lillian Garrett — Address: Pasadena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Cardiac — INTERVAL BETWEEN ONSET AND DEATH: Instant
434.4
DUE TO (b):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt M.D.
EXAMINER'S NAME (Type): E. Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 11-23-66

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-28-66
23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: Harry W. Haight — ADDRESS: Sykesville, Md.
25o. REC'D BY REGISTRAR — DATE: NOV 28 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15073

CERTIFICATE OF DEATH

15074

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie c. LENGTH OF STAY IN 1b: 50 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie 021
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): North Arundel Hospital	d. STREET ADDRESS: 1902 Crain Highway e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Henry	Middle: M	Last: Gerber	4. DATE OF DEATH: Month: November	Day: 6 — Year: 1966
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: Feb. 25, 1900	9. AGE (In years last birthday): 66 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stationary Engineer	10b. KIND OF BUSINESS OR INDUSTRY: Retired	11. BIRTHPLACE (County & State, or foreign country): Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: CALVIN M.		14. MOTHER'S MAIDEN NAME: VIOLA CHRONISTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): Unknown	16. ~~SOCIAL SECURITY NO.~~ Medicare # 217-07-1097	17. INFORMANT: CALVIN M. GERBER — Address: GLEN BURNIE, MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): Congestive Heart Failure — months

DUE TO (c): Arteriosclerotic Heart disease

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL OISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ ~~CAUSE OF DEATH~~ (IF EITHER, NOTIFY MEOICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)			
20c. TIME OF INJURY Month, Doy, Yeor Hour, a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 11/4/66, 19___ to 11/6/66, 19___, that (I) (we) last saw the deceased alive on 11/5/66 19___, and that death accurred at 12:20 P M, from causes and an the date stated abave.

22a. SIGNATURE: J. B. Ramirez M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: 11/6/66	
22c. PHYSICIAN'S NAME (Type): J. B. RAMIREZ MD	22d. ADDRESS: 3927 ANNAPOLIS RD Baltimore 27 1672 NORTHBOURNE RD Baltimore 12		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE THEREOF: 11-9-1966	23c. NAME OF CEMETERY OR CREMATORY: GREENMOUNT	23d. LOCATION (City or Town): YORK	(County): YORK	(State): PA.
24. FUNERAL DIRECTOR: Henry K. Dodson Jr.	ADDRESS: York, Pa.	25a. REC'D BY REGISTRAR DATE: NOV 10 1966	25b. REGISTRAR'S SIGNATURE: J. Charles Judge		

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15074

CERTIFICATE OF DEATH

15075

1. PLACE OF DEATH
a. COUNTY: A A Co. — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rugby Hall Arnold
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Cavalier Drive

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD. b. COUNTY: A.A.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rugby HALL Arnold D. 21
d. STREET ADDRESS: CAVALIER Drive.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen Middle: Jane Last: GIBBONS
4. DATE OF DEATH: Month: 11-3-66 Day: Year: 19
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 25, 1920
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10b. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (County & State, or foreign country): Baltimore md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Herbert O Gier
14. MOTHER'S MAIDEN NAME: ELIZABETH Ballard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: EDWARD E. GIBBONS JR. #2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Center Failure
1930
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Malignant Brain Tumor.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1959, 19__, to 1966, 19__, that (I) (we) last saw the deceased alive on 10-12-66 19__, and that death occurred at 7:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert R. Hahn — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-3-66.
22c. PHYSICIAN'S NAME (Type): Robert R. Hahn
22d. ADDRESS: P.O. Box 73 Severna Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11-5-66
23c. NAME OF CEMETERY OR CREMATORY: St. MARGARETS
23d. LOCATION (City, town or county) (State): St. MARGARETS MD.

24. FUNERAL DIRECTOR: John M. Taylor & Sons ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: NOV 7 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15075

CERTIFICATE OF DEATH

15076

1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNAPOLIS NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY A. ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 021 14 FISK CIRCLE ANNAPOLIS, MD
d. STREET ADDRESS VAN BUREN & BAY RIDGE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First MORRIS Middle Lost GOLDMAN
4. DATE OF DEATH Month NOV Doy 18 Year 1966
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12-1-1875
9. AGE (In years last birthday) 90
IF UNDER 1 YEAR Months Doys
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE PAINTER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) RUSSIA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME SIMON GOLDMAN
14. MOTHER'S MAIDEN NAME CLARA LEMANS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 060-28-7986
17. INFORMANT Address ANNAPOLIS NURSING HOME.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the rectum
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH unknown
154X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 6/4, 1966 to 11/18, 1966, that (I) (~~we~~) last saw the deceased alive on 11/18 1966, and that death occurred at 9:45 P.M., from causes and on the date stated above.

22a. SIGNATURE Richard I. Hochman
M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 11/18/66
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.
22d. ADDRESS 59 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 11/20/66
23c. NAME OF CEMETERY OR CREMATORY WELLWOOD
23d. LOCATION (City or Town) (County) (State) Farmingdale, Long Island, N.Y.
24. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. Inc., 6010 Reisterstown
25a. REC'D BY REGISTRAR DATE NOV 22 1966
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15076

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15077

1. PLACE OF DEATH
   a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): ANNAPOLIS GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Maryaland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside carporate limits, write RURAL and give neorest town): Annapolis — 02-1
   d. STREET ADDRESS: 1 Murray Avenue - Apt. #3
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GLORIA — Middle Lorainne — Last Goudreau / GOODREAU
4. DATE OF DEATH: Month 11 — Doy 29 — Year 1966
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ — NEVER MARRIED ☒ — WIDOWED ☐ — DIVORCED ☐
8. DATE OF BIRTH: 10-1-66
9. AGE (In yeors lost birthday) yrs.: IF UNDER 1 YEAR Months 8 weeks, Doys — IF UNDER 24 HRS. Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (Stote or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Edward G. Goudreau, Jr.
14. MOTHER'S MAIDEN NAME: Patricia Anne Hall
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Patricia Anne Goudreau — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Interstitial pneumonitis (SDII) — INTERVAL BETWEEN ONSET AND DEATH
525X
DUE TO
(b):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I taak charge of the remains described above, held an Autapsy ☒, Inspection ☐, Inquiry ☐, and in my apinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D. — M.D.
EXAMINER'S NAME (Type): WERNER U. SPITZ, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: 11-29-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-2-66
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest
23d. LOCATION (City or Town) (County) (State): Annapolis Anne Arundel MD

24. FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
6-211448

25a. REC'D BY REGISTRAR DATE: DEC 5 1966
25b. REGISTRAR'S SIGNATURE: Charles Jones

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15077

CERTIFICATE OF DEATH

15078

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel Co. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b: 4 mo.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Annapolis Nursing & Conv. Center, Bay Ridge Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: A.A. Co.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
   d. STREET ADDRESS: Rt. #3 Box 521
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Noreen — Middle A. — Last Haas (XXXX)

4. DATE OF DEATH: Month Nov — Day 26 — Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 18, 1890

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Char lady

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James Garden

14. MOTHER'S MAIDEN NAME: Annie Weser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: 3108 Winter Green Ave
Althea Jackson Wash, D.C. 20028

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic carcinoma of the bowel — INTERVAL BETWEEN ONSET AND DEATH: 10 mos.
DUE TO (b): to liver, lung, brain, peritoneal cavity.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1539

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 1966 to Nov., 1966, that (I) (we) last saw the deceased alive on 11-25 1966, and that death occurred at 4.30 P.M. from causes and on the date stated above.

22a. SIGNATURE: Pete F. Verkouw — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-26-66

22c. PHYSICIAN'S NAME (Type): Dr. Verkouw

22d. ADDRESS: 1407 Forest Dr. Annapolis, Md

23a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): Burial

23b. DATE THEREOF: 11-29-1966

23c. NAME OF CEMETERY OR CREMATORY: Fox Lincoln

23d. LOCATION (City or Town) (County) (State): Prince George County Md

24. FUNERAL DIRECTOR: Robert Mattingly Funeral Home

ADDRESS: 11th St. SE Washinct on, D.C.

25a. REC'D BY REGISTRAR DATE: NOV 29 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15078

CERTIFICATE OF DEATH

15079

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G MEADE
c. LENGTH OF STAY IN 1b: 1 Hr, 45 Mins
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): KIMBROUGH ARMY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): GLEN BURNIE 02.1
d. STREET ADDRESS: 7 SOUTH MEADOW DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Doy	Year
MARGARET	CATHERINE	HALL	NOVEMBER	17	19 66

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	IF UNDER 1 YEAR Months	Doys	IF UNDER 24 HRS. Hours	Min.
FEMALE	CAU		July 1923	43 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of warking life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Stote, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Secretary	Plastic Firm	Passiac, New Jersey	USA

13. FATHER'S NAME: Edwin Burgoyne
14. MOTHER'S MAIDEN NAME: Jessie McKay Gallette

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give wor or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WWII 1942-44	139-14-5483	Arthur P.Hall,7 S Meadow Dr. Glen Burnie,Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): SUBARACHNOID HEMORRHAGE
DUE TO
(b):
DUE TO
(c):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
331 X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)	20f. (City or town) (County) (Stote)

21. I certify that ☒ (this hospital) attended the deceased from 1pm 17 Nov, 1966, to 2:45pm 17 Nov 66, that ☒ (we) last saw the deceased alive an 17 Nov 19 66, and that death accurred at 2:45pM, from causes and on the date stated obave.

22o. SIGNATURE: Joseph C. DiMarco Cptmc M.D. ATTENDING PHYS. ■ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 17 Nov 66
22c. PHYSICIAN'S NAME (Type): JOSEPH C.DiMARCO,CPT,MC
22d. ADDRESS: KIMBROUGH ARMY HOSP,FT GEO G MEADE,MD

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)
Burial	21 Nov. 66	Glen Haven Memorial	Glen Burnie, Md.

24. FUNERAL DIRECTOR ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Kirkley Funeral Home, Glen Burnie, Md.	NOV 22 1966	J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15079

CERTIFICATE OF DEATH

15080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside carparate limits, write RURAL and give neorest tawn): Annapolis
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Calvert
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn): Dares Beach
d. STREET ADDRESS: Prince Fredrick
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type ar print): First: William — Middle: Timothy — Last: HALSTEAD

4. DATE OF DEATH: Month: November — Day: 8 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 8, 1966

9. AGE (In years lost birthday) yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most af working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, ar fareign cauntry): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William Turner Halstead

14. MOTHER'S MAIDEN NAME: Joyce A. Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) — (If yes give war ar dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: William T. Halstead, Address: Prince Fredrick Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hydrocefbolus
DUE TO
752X
Canditians, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b): —
DUE TO
(c): —

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Prematurity

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Haur a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Hame, farm, factary, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 11/8, 19 66, to 11/8, 19 66, that (I) ~~(we)~~ last saw the deceased alive an 11/8 19 66, and that death accurred at ~~5:01~~ A.M. from causes and an the date stated above.

22a. SIGNATURE: Robert A. Riley Jr. M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/11/66

22c. PHYSICIAN'S NAME (Type) ROBERT A. RILEY, JR

22d. ADDRESS 95 CATHEDRAL ST ANNAPOLIS, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 14, 1966

23c. NAME OF CEMETERY OR CREMATORY: Our Lady Star of the Sea Cemetery

23d. LOCATION (City ar Tawn) (County) (State): Solomons Calvert, Md.

24. FUNERAL DIRECTOR: A. A. Harkness & Son — ADDRESS: Box 34 Mutual Post Republic, Md.

25a. RECD BY REGISTRAR DATE: NOV 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

G-23537

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15080 **CERTIFICATE OF DEATH** 15081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 707 Crain Highway N.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 707 Crain Highway N.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: S. — Last: Harding

4. DATE OF DEATH: Month: Nov. — Day: 11, — Year: 1966

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3 May 1903

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Prop. - Service Sta.

10b. KIND OF BUSINESS OR INDUSTRY: Ret.

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George I. Harding

14. MOTHER'S MAIDEN NAME: Lillie May Ruby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ——

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Mildred Praley, Address: Glen Burnie, Md. Ritchie Hghy.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Adenocarcinoma of the Lung — INTERVAL BETWEEN ONSET AND DEATH: 1 yr mo
165X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from October, 1966, to the date of death 19—, that (I) (we) last saw the deceased alive on 11/4 1966, and that death occurred at 11:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Wayne B. Tate M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 11/14/66

22c. PHYSICIAN'S NAME (Type): Wayne B. Tate, M. D. — 22d. ADDRESS: 108 Central Ave., Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 15 Nov. 1966 — 23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial — 23d. LOCATION (City, town or county) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: NOV 15 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15081

CERTIFICATE OF DEATH

15082

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   e. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitel, give street address): North Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
   d. STREET ADDRESS: Rt. 6, Box 249, Mt. Pleasant Beach
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Gerald	Gordon	Hartley		November	24	1966

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White		May 14, 1919	47 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cab driver	Taxi	Lonaconing, Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William McKiney Hartley	Irene Grindle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	W.W. II	217-10-5943	Rita Matilda Hartley - same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute myocardial infarction	1 hour
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Coronary arteriosclerotic heart disease	5 years
DUE TO (c)		

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 7/22, 1956, to 11/24, 1966, that (I) ~~(we)~~ last saw the deceased alive on 9/30 1966, and that death occurred at 4 A M, from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
R. M. McLaughlin					11/25/66

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
R. M. McLaughlin	Pasadena, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	Nov. 28, 1966	Baltimore National	Baltimore, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George J. Gonce- 4001 Ritchie Hgwy., Baltimore	NOV 29 1966	J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15082

CERTIFICATE OF DEATH

15083

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 4 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
d. STREET ADDRESS: Box 34, Rt. 5 (Mag. Bridge Rd.)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Henry — Last: MARTSELL

4. DATE OF DEATH: Month: November — Doy: 16 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 25, 1895

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Chev. Plant

11. BIRTHPLACE (County & State, or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Israel Houston Hartsell

14. MOTHER'S MAIDEN NAME: Mandy Malinda Hartsell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dotes of service): None

16. SOCIAL SECURITY NO.: 243-01-8535

17. INFORMANT — Address: Mrs. Dollie A. Hartsell (Wife) Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction
DUE TO (b): Coronary artery disease
DUE TO (c): Arteriosclerosis
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
4201
INTERVAL BETWEEN ONSET AND DEATH: few hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): emphysema, pulmonary

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on Nov. 15 19 66 and that death occurred at 5:40 A.M., from causes and on the date stated above.

22a. SIGNATURE: Ray M. Smith — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 16 Nov, 1966

22c. PHYSICIAN'S NAME (Type): RAY M. SMITH MD

22d. ADDRESS: Severn Park Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 19, 1966

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR — ADDRESS: Richard V. Singleton — Glen Burnie, Md.

25a. RECD BY REGISTRAR DATE: NOV 21 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15083

CERTIFICATE OF DEATH

15084

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 1111
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): North ~~Anne~~ Arundel Hosp

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena. (High Point) 021
d. STREET ADDRESS: 248 Riverside Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward Middle: Thomas Last: Heaphy

4. DATE OF DEATH: Month: November Day: 3 Year: 1966

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 29. 1914
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Personnel Mgr
10b. KIND OF BUSINESS OR INDUSTRY: Cat's Paw (mfg)
11. BIRTHPLACE (County & State, or foreign country): Baltimore md
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Harry Heaphy
14. MOTHER'S MAIDEN NAME: Rose Andrews

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 212-10-1580
17. INFORMANT: MR James O. Heaphy (Son) Address 107 Bonnie View Rd Glen Burnie

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hiatus Hernia - 2 years duration
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 2/6, 1966, to 11/3, 1966, that (I) (~~we~~) last saw the deceased alive on 11/3 1966, and that death occurred at 6 P.M., from the causes and on the date stated above.

22a. SIGNATURE: R.M. McLaughlin M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: November 4. 1966
22c. PHYSICIAN'S NAME (Type): R.M. McLaughlin, M.D.
22d. ADDRESS: 3708 Mountain Rd. Pasadena, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov 7, 1966
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Park
23d. LOCATION (City, town or county) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR ADDRESS: Richard V. Singleton Glen Burnie, Md
25a. REC'D BY REGISTRAR DATE: NOV 9 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

3 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15084

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15085

1. **PLACE OF DEATH**
   a. COUNTY: AA.Co. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis - MD.
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.M - Annie Arundel - Gen.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MD — b. COUNTY: AACO
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gambrills - MD 021
   d. STREET ADDRESS: Wail Chapel Rd.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Leonard — Middle: — Last: Hebron

4. **DATE OF DEATH**: Month: 11 — Day: 12 — Year: 1966

5. SEX: M

6. COLOR OR RACE: N

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/24/10

9. AGE (In years last birthday): 56 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Hebron

14. MOTHER'S MAIDEN NAME: Hazel Banks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW2

16. SOCIAL SECURITY NO.: —

17. **INFORMANT**: Hortense Baynes — Address: Sister

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): arteriosclerosis generalized — INTERVAL BETWEEN ONSET AND DEATH: Indef.
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): 4500
   DUE TO
   (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E Lindsay M.D.

EXAMINER'S NAME (Type): E. Linbrook.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: 11.12.66

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 11-17-66

23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat.

23d. LOCATION (City or Town) (County) (State): Arlington Virginia

24. FUNERAL DIRECTOR — ADDRESS: H.L. Washington & Sons, 4925 Deane Ave. N.E. — D.C.

25a. FILED BY REGISTRAR — DATE: NOV 21 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

15085

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G582 11/15/66 mh

CERTIFICATE OF DEATH

15086

1. PLACE OF DEATH
a. COUNTY: A-A County — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Annapolis Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD. — b. COUNTY: A.A.
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): EDGEWATER
d. STREET ADDRESS: Rt #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Catherine — Middle: E. — Last: Higdon

4. DATE OF DEATH: Month: Nov — Day: 4 — Year: 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: MAY 16-1889 (1890)

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SECRETARY

10b. KIND OF BUSINESS OR INDUSTRY: CIVIL SERVICE

11. BIRTHPLACE (County & State, or foreign country): WOODWARD MASS

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Terrance Maguire

14. MOTHER'S MAIDEN NAME: Bridgett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Thomas J. Higdon — Address: RT 2 Box 213E8 EDGEWATER MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO
(b): Myocard infarction (acute) — Days
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized arterio sclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/6, 19 66, to 11/4/66, 19___, that (I) (we) last saw the deceased alive on 11/3/66, 19___, and that death occurred at 8:20 A.M., from causes and on the date stated above.

22a. SIGNATURE: Gerard Chuvet — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/5/66

22c. PHYSICIAN'S NAME (Type): GERARD CHUVET

22d. ADDRESS: 121 Cathedral St, Annapolis Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 11-8-1966

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT. CEM.

23d. LOCATION (City or Town) (County) (State): ARLINGTON VA.

24. FUNERAL DIRECTOR: JOHN M. TAYLOR'S SONS — ADDRESS: ANNAPOLIS MD

25a. REC'D BY REGISTRAR DATE: NOV 10 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

(M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15086

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15087

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): ~~Annapolis~~ Glen Burnie
   c. LENGTH OF STAY IN 1b: DOA
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): North Arundel General

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Annapolis~~ Pasadena
   d. STREET ADDRESS: Rt.9 Box 230
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

02-1

99

3. **NAME OF DECEASED** (Type or print): First ~~Elizabeth~~ Mabel — Middle H. — Lost Holland

4. **DATE OF DEATH**: Month 11 — Day 22 — Year 19 66

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 16 Nov. 1884

9. AGE (In years lost birthday): 82 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ — IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): East New Market, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Higgins

14. MOTHER'S MAIDEN NAME: Mary E. Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address: Mrs. Jane Bready, Severna Park, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH
4221
DUE TO
Conditions, if any, which gove rise to immediate cause (a), stoting the underlying couse lost.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ partial

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

Partial

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county)

22. DATE SIGNED: 11/22/66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 25 Nov. 66

23c. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: NOV 28 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15087

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15088

1. **PLACE OF DEATH**
   a. COUNTY: B.A. Co. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.M. - North Arundel Hosp

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MD
   b. COUNTY: AACO
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): N. Linthicum — 02-1
   d. STREET ADDRESS: 7 Colonial Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First FRANK — Middle J. — Last HRUBES

4. **DATE OF DEATH**: Month 11 — Day 25 — Year 19 66

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-7-1886

9. AGE (In years last birthday): 80 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (State or foreign country): AUSTRIA

12. CITIZEN OF WHAT COUNTRY? AUSTRIA

13. FATHER'S NAME: FRANK HRUBES

14. MOTHER'S MAIDEN NAME: JOANNA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 218-01-4430

17. **INFORMANT** Address: Mrs. Victoria Hrubes, 7 Colonial Drive 21090

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): E. Linthicum

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 11-27-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-29-66

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR ADDRESS: Howard H. Hubbard, 4107 Wilkens Avenue, 21229

25a. REC'D BY REGISTRAR DATE: NOV 29 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15088

CERTIFICATE OF DEATH

16538

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 7 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Baltimore 30, 4/
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): #20327 — First: Alice — Middle: — Last: Hudson

4. DATE OF DEATH: Month: 11 — Day: 26 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6/30/97

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Insufficiency
DUE TO (b): Arteriosclerotic Hypertensive Cardiovascular
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
4 20.1
INTERVAL BETWEEN ONSET AND DEATH: Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congestive Heart Failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. ---------- 19--

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/9/ , 19 59, to 11/26/, 1966, that (I) (we) last saw the deceased alive an 11/28/ 19 66, and that death occurred at 9:40 A.M., from causes and on the date stated above.

22a. SIGNATURE: Hildagard Heard Reissman M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11/28/66

22c. PHYSICIAN'S NAME (Type): Hildagard Heard Reissman

22d. ADDRESS: Crownsville State Hospital, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 12/20/66

23c. NAME OF CEMETERY OR CREMATORY: University Md

23d. LOCATION (City or Town) (County) (State): Balt Md

24. FUNERAL DIRECTOR — ADDRESS: Annapolis, Maryland
William Reese II 108 W. Washington St.

25a. REC'D BY REGISTRAR — DATE: DEC 22 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15089

CERTIFICATE OF DEATH

15089

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 12 CHESTON AVE

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD. — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): ANNAPOLIS 02.1
d. STREET ADDRESS: 12 CHESTON AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: VIRGINIA — Middle: REICH — Lost: HYDE

4. DATE OF DEATH: Month: 11 — Doy: 19 — Yeor: 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-4-1911

9. AGE (In yeors last birthday): 55 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME

10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE

11. BIRTHPLACE (County & Stote, or foreign country): WASH. D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: CHESTER M. REICH

14. MOTHER'S MAIDEN NAME: FLORENCE ANGELO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: BENJAMIN J. HYDE — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 minute
DUE TO (b): Coronary artery sclerosis — 10 yrs.
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1955, to Nov., 1966, that (I) (we) last saw the deceased alive on Nov. 10 1966, and that death occurred at 8:45 M, from causes and on the date stated above.

22a. SIGNATURE: John Hedeman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/22/66

22c. PHYSICIAN'S NAME (Type): John Hedeman

22d. ADDRESS: Forest Drive. Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 11-22-66

23c. NAME OF CEMETERY OR CREMATORY: CEDAR Bluff

23d. LOCATION (City or Town) (County) (State): ANNAPOLIS MD.

24. FUNERAL DIRECTOR: John M. Taylor Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: NOV 23 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15090

CERTIFICATE OF DEATH

15090

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town): Annapolis
d. STREET ADDRESS: 1204 West Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Doy	Year
Alvin		JACKSON	November	13	1966

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In yeors last birthday)	IF UNDER 1 YEAR Months	Doys	IF UNDER 24 HRS. Hours	Min.
Male	White		November 24, 1895	70 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Stote, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
VENETIAN BLINDS	WINDOW BLINDS	Jewett, Georgia	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JAMES M. JACKSON	TOLINE BRADLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
YES	WWI		PAULINE E JACKSON #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
DUE TO
(b):
DUE TO
(c):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost. 4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o): Carcinoma of prostate

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (this haspital) attended the deceased from June, 1955, to Nov, 1966 that (I) (we) last saw the deceased alive an Nov. 13 1966, and that death accurred at 1:20 A.M. from causes and an the date stated above.

22a. SIGNATURE: J L Hedeman — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/14/66
22c. PHYSICIAN'S NAME (Type): JOHN L HEDEMAN
22d. ADDRESS: FOREST DR ANNAPOLIS MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	11-15-66	Hillcrest	Annapolis MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John M. Taylor Sons	Annapolis, Md.	DATE NOV 17 1966	J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremotion, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15091 15091

1. PLACE OF DEATH
a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1 mo, 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Baltimore 30.4
d. STREET ADDRESS: 220 Beal Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): 33459 First: Edward Middle: J. Lost: Jackson
4. DATE OF DEATH: Month: 11 Doy: 18 Year: 1966

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 10/16/06
9. AGE (In yeors lost birthday): 60 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Will Jackson
14. MOTHER'S MAIDEN NAME: Tamie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No
16. SOCIAL SECURITY NO.: 220-07-8079
17. INFORMANT Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Carcinoma of the Pancreas with Generalized Metastasis
157X
Conditions, if ony, which gave rise to immediate couse (o), stoting the underlying couse last.
(b) DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Anemia, secondary to the above; Carcinoma of the Parotid Gland(left)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.): ----------
20c. TIME OF INJURY Month, Doy, Yeor: ---Hour a.m. p.m.--- 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.): ----------
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/31, 1966, to 11/18/1966, that (I) (we) last saw the deceased alive on 11/18/ 1966, and that death occurred at 2:40 P.M., from causes and on the date stated above.

22o. SIGNATURE: Lionel McHenry Mapp M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 11/18/66
22c. PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M.D.
22d. ADDRESS: Crownsville State Hospital, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-23/66
23c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cemty.
23d. LOCATION (City or Town) (County) (State): Balto. Md.

24. FUNERAL DIRECTOR: C O Wilson ADDRESS: 2004 Orleans St.
25o. REC'D BY REGISTRAR DATE: NOV 22 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15092 **CERTIFICATE OF DEATH** 15092

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel
   MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: 4 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Plaza Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: A. A.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 02.1
   d. STREET ADDRESS: 50 Shaw Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jerry Middle: James Last: Jackson

4. DATE OF DEATH: Month: 11 Day: 7 Year: 1966

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Sep

8. DATE OF BIRTH: 4/25/13

9. AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNKNOWN (General Williams)

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Jones Station md.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): NO

16. SOCIAL SECURITY NO.: 5271

17. INFORMANT: Irene D. Williamson Address: Box 470 Pk, Md. Severna

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion	1 day
DUE TO (b)	Pulmonary edema	Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Chronic Emphysema	Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/3, 19 66 to 11/7, 19 66, that (I) (we) last saw the deceased alive on 11/7/66, and that death occurred at 11 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Richard H. Hunt M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Richard H. Hunt

22d. ADDRESS: 100 Cherry Lane, Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov 10-66

23c. NAME OF CEMETERY OR CREMATORY: Carpenters Hill

23d. LOCATION (City, town or county) (State): Anne Arundel Co - Md

24 FUNERAL DIRECTOR'S SIGNATURE: C & E. Hicks III ADDRESS: Annapolis, Md

25a. REC'D BY REGISTRAR DATE: NOV 14 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 5-63

Dr. Shipley

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15093

CERTIFICATE OF DEATH

15093

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: A. A. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PROVIDENCE
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 236 PURITAN PLACE

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: M.D. — b. COUNTY: A. A.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS, MD. 21
   d. STREET ADDRESS: 58 MD. AVE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: ETHEL — Middle: FELDMEYER — Lost: KING

4. **DATE OF DEATH**: Month: 11 — Day: 4 — Year: 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-28-1884

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME

10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE

11. BIRTHPLACE (County & State, or foreign country): ANNAPOLIS MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES G. FELDMEYER

14. MOTHER'S MAIDEN NAME: ELIZABETH DAWES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address: MRS. JAMES O. OGDEN #1

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC C V D.
   DUE TO (b):
   Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO (c):
   4221
   INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1955, to 11-4, 1966, that (I) (we) last saw the deceased alive on 11-1-1966, and that death occurred at 7:30 P.M., from couses and on the date stated above.

22a. SIGNATURE: Frank M. Shipley — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-7-66

22c. PHYSICIAN'S NAME (Type): F M SHIPLEY

22d. ADDRESS: 121 CATHEDRAL ST. ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 11-7-66

23c. NAME OF CEMETERY OR CREMATORY: U.S.N. ACADEMY

23d. LOCATION (City or Town) (County) (State): ANNAPOLIS MD.

24. FUNERAL DIRECTOR: John M. Taylor Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: NOV 10 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15094

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15094

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North Arundel
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: NEW YORK — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Webster
d. STREET ADDRESS: 818 Ridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AGNES — Middle S — Last KLAVER

4. DATE OF DEATH: Month November — Day 10 — Year 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/11/94
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED SCHOOLTEACHER
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (State or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE SCHOEMAKER
14. MOTHER'S MAIDEN NAME: ELIZABETH HERMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: -------
17. INFORMANT Address: MR. RICHARD KLAVER, NEWBURN, NORTH CAROLINA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Transection of lower medulla — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Driver in truck-auto collision
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 3:54 p.m. 11/10 1966
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): highway
20f. (City or town) (County) (State): N. Arundel Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: November 11, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11-14-66
23c. NAME OF CEMETERY OR CREMATORY: WEBSTER RURAL CEMETERY
23d. LOCATION (City or Town) (County) (State): WEBSTER, NEW YORK

24. FUNERAL DIRECTOR — ADDRESS: Howard H. Hubbard, 4107 Wilkens Avenue, 21229
25a. REC'D BY REGISTRAR DATE: NOV 14 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15095

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15095

1. **PLACE OF DEATH**
   a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North Arundel
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): North Arundel Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: NEW YORK — b. COUNTY:
   c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Webster
   d. STREET ADDRESS: 818 Ridge Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First HERMAN — Middle L. — Last KLAVER

4. **DATE OF DEATH**: Month November — Day 10, — Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 3/12/94

9. AGE (In years last birthday): 72 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED - TIRE CO.

10b. KIND OF BUSINESS OR INDUSTRY: --------

11. BIRTHPLACE (State or foreign country): NEW YORK

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN F. KLAVER

14. MOTHER'S MAIDEN NAME: ROSALIA SULASKY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
    (If yes give war or dates of service): W W I

16. SOCIAL SECURITY NO.: 073-03-4999

17. **INFORMANT** Address: MR. RICHARD KLAVER, NEWBURN, NORTH CAROLINA

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): Multiple severe injuries — INTERVAL BETWEEN ONSET AND DEATH:
    DUE TO
    Conditians, if any, which gave rise to immediate cause (a), stating the underlying cause last.
    (b):
    DUE TO
    (c):

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Passenger in truck-auto collision

20c. TIME OF INJURY Month, Day, Year: Hour 3:54 p.m. 11/10 19 66

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): highway

20f. (City or town) (County) (State): North Arundel, Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

22. DATE SIGNED: November 11, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 11-14-66

23c. NAME OF CEMETERY OR CREMATORY: WEBSTER RURAL CEMETERY

23d. LOCATION (City or Town) (County) (State): WEBSTER, NEW YORK

24. FUNERAL DIRECTOR — ADDRESS: Howard H. Hubbard, 4107 Wilkens Avenue, 21229

25a. REG'D BY REGISTRAR DATE: NOV 14 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15096 (duplicate) 15096

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: A.A. — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Ferndale – Glebe area
   c. LENGTH OF STAY IN 1b: 17 yrs –
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 6 – Dickmore Ave.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md.
   b. COUNTY: AA. Co.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jane
   d. STREET ADDRESS: 121
   a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: John — Middle: George — Last: Koenrig

4. **DATE OF DEATH**: Month: Nov – Day: 8 – Year: 1966

5. SEX: M.

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar – 20 – 1902

9. AGE (In years last birthday): 64 yrs.
   IF UNDER 1 YEAR: Months | Days
   IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shop Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Auto.

11. BIRTHPLACE (County & State, or foreign country): Baltimore Md –

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Henry Koenrig.

14. MOTHER'S MAIDEN NAME: Lena Hoffman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
    (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 213-05-8289

17. INFORMANT: Joseph F. Koenrig — Address: R3 – B109 – Bowie Md –

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio – Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 1960 –

DUE TO (b): – Cancer of rt. lung – Operated — 2-3 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Ca removed L lung Oct. 6 – 1966 –

163X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan ....., 1966, to Nov 8 ....., 1966, that (I) (we) last saw the deceased alive on 11/8/66 19....., and that death occured at 5 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Chas. L. Ball Jr – M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/8/66

22c. PHYSICIAN'S NAME (Type): Charles L. Ball, Jr. – M.D.

22d. ADDRESS: Lanthicum Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 13, 1966

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Park

23d. LOCATION (City, town or county) (State): Glen Burnie Md –

24. FUNERAL DIRECTOR'S SIGNATURE: R V Singleton

ADDRESS: Singleton Funeral Home Glen Burnie, Md. –

25a. REC'D BY REGISTRAR DATE: NOV 10 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15097

CERTIFICATE OF DEATH

15097

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: A.A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 28 Bristol Dr.

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: MD. — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): ANNApolis — C2-1
d. STREET ADDRESS: 28 Bristol Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD — Middle C. — Lost KUHL
4. DATE OF DEATH: Month 11 — Day 27 — Year 19 66
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8. DATE OF BIRTH: 2-29-1908
9. AGE (In yeors last birthdoy): 58 yrs.
IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RESTAURANT
10b. KIND OF BUSINESS OR INDUSTRY: FOOD
11. BIRTHPLACE (County & Stote, or foreign country): BALTO. MD.
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: EDWARD A. KUHL
14. MOTHER'S MAIDEN NAME: SADIE STAAB

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give wor or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: GERTRUDE C. KUHL. — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma of the Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 6 months
157X
DUE TO
(b):
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10/6, 1966, to 11/26, 1966, that (I) (we) last saw the deceased alive on 11/26/66 19___, and that death occurred at 3p M, from causes and on the date stated above.

22a. SIGNATURE: Gerard Eberel — M.D. — ATTENDING PHYS. ☑ — MED. DIRECTOR ☐ — STAFF PHYS. ☐
22b. DATE SIGNED: 11/27/66
22c. PHYSICIAN'S NAME (Type): GERARD EBERLE
22d. ADDRESS: 121 CATHEDRAL ST. ANNAPOLIS MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11-30-66
23c. NAME OF CEMETERY OR CREMATORY: HILLCREST
23d. LOCATION (City or Town) (County) (State): ANNAPOLIS A.A. MD.

24. FUNERAL DIRECTOR — ADDRESS: John M. Taylor & Sons Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: NOV 29 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1749 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15098

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15098

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Queenstown (Severn)
   c. LENGTH OF STAY IN 1b
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Jones Road, Queenstown

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Queenstown (Severn) 02-1
   d. STREET ADDRESS: Jones Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First James — Middle — Last LAMONS

4. **DATE OF DEATH**: Month Nov — Day 7 — Year 19 66

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday): 44 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. **INFORMANT** Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, Bilateral — INTERVAL BETWEEN ONSET AND DEATH
491X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fatty alteration of Liver

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐ PARTIAL

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) PARTIAL

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: NOV. 8th 1966

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF 11.28.66

23c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School

23d. LOCATION (City or Town) (County) (State) Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS

25a. REC'D BY REGISTRAR DATE NOV 30 1966

25b. REGISTRAR'S SIGNATURE J. Charles Yeager

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15099

CERTIFICATE OF DEATH

15099

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): GLEN BURNIE
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in haspitol, give street address): NORTH ARUNDEL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside carporote limits, write RURAL and give neorest town): HANOVER 02.1
d. STREET ADDRESS: BOX 55
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALFRED — Middle — Last LONG
4. DATE OF DEATH: Month NOVEMBER — Day 30 — Year 1966

5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: FEBRUARY 4, 1882
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind af wark done during most af warking life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD
11. BIRTHPLACE (County & Stote, or foreign country): ANNE ARUNDEL CO., MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Washington Long
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only ane cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial audosis — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
DUE TO (b): Diabetes Mellitus — 1 year
DUE TO (c): Left ventricular failure — 1 day
Conditians, if any, which gave rise to immediate couse (a), stating the underlying couse last.
Arteriosclerotic heart Disease — years
260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I ar Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at wark ☐
20e. PLACE OF INJURY (Home, form, factary, street, affice bldg., etc.)
20f. (City ar tawn) (County) (Stote)

21. **I certify** thot (I) (this hospitol) attended the deceased from 11/22, 1966 to 11/30, 1966, that (I) (we) last saw the deceased olive on 11/30 1966, and thot deoth occurred at 4:47 A.M. from causes ond on the dote stoted above.

22a. SIGNATURE: M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/30/66
22c. PHYSICIAN'S NAME (Type): MAX C FRANK MD
22d. ADDRESS: 425 SE Ritchie Hwy - Glen Burnie MD 21061

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/3/66
23c. NAME OF CEMETERY OR CREMATORY: Saints Rest.
23d. LOCATION (City ar Town) (County) (State): Harman MD.

24. FUNERAL DIRECTOR: Charles A. Rice — ADDRESS: 661 W. Baltimore St. City 30
25a. REC'D BY REGISTRAR DATE: DEC 1 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15100

CERTIFICATE OF DEATH

15100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 516 W. Mulberry
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): #33732 — First: William — Middle: B. — Last: Lovett
4. DATE OF DEATH: Month: 11 — Day: 6 — Year: 19 66
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/15/1894
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter (ret.)
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (County & State, or foreign country): ~~Virginia~~ TENN
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Lovett
14. MOTHER'S MAIDEN NAME: Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO. 230-10-9437 ~~259-10-1437~~
17. INFORMANT: Hospital Records — Address: AS ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Brain Syndrome
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. ---------- 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/2/ 1966 to 11/6/ 1966, that (I) (we) last saw the deceased alive on 11/6/ 1966, and that death occurred at 7:45 P.M. from causes and on the date stoted above.

22a. SIGNATURE: L. Benedict M.D.
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 11/7/66
22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.
22d. ADDRESS: Crownsville P.O., Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/10/66
23c. NAME OF CEMETERY OR CREMATORY: Balto. National Cemetery
23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: Wm. Cook-Brooks F.H. — ADDRESS: Balto., Md. 21202 1217 St. Paul St.
25a. REC'D BY REGISTRAR DATE: NOV 9 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

15101 — Reg. Dist. No. 15101

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: 15 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: N. Arundel Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
d. STREET ADDRESS: Fairview Beach Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Oscar Edward — Middle — Last LOWRY Sr.

4. DATE OF DEATH: Month 11 — Day 5 — Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 27, 1881

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printer Ret.

10b. KIND OF BUSINESS OR INDUSTRY: Lord Balto. Press

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James D. Lowry

14. MOTHER'S MAIDEN NAME: Ida Bell Dulin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-01-3342

17. INFORMANT: Mrs. Katherine Lowry — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 20, 1966, to Nov. 5, 1966, that I last saw the deceased alive on Nov. 4, 1966, and that death occurred at 7:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Brady Smith M.D. — ADDRESS (Street, city or town, state): 8471 E. Smallwood Rd — DATE SIGNED: 11/7/66

PHYSICIAN'S NAME (Type): D. BRADY SMITH — PASADENA, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 8, 1966

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Pk.

22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: George J. Gonce — ADDRESS: 4001 Ritchie Hwy. (21225)

24a. REC'D BY REGISTRAR DATE: NOV 10 1966

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

George J. Gonce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15102

CERTIFICATE OF DEATH

15102

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   d. STREET ADDRESS: 13 Monroe Ct.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Nicholas; Middle:; Last: LUONGO

4. **DATE OF DEATH**: Month: November; Day: 13; Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 13, 1902

9. AGE (In years last birthday): 63 yrs.
   IF UNDER 1 YEAR: Months; Days
   IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): pressman

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

11. BIRTHPLACE (County & State, or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Luongo

14. MOTHER'S MAIDEN NAME: Theresa (maiden name unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no. (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 216-44-9286

17. INFORMANT: Mrs. Josephine Luongo — Address: Same as #2 above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Adenoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b):
   DUE TO
   (c):
   163X

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 26 OCT, 1966, to 13 NOV, 1966 that (I) (we) last saw the deceased alive on 12 NOV, 1966, and that death occurred at 2:05 A.M. from causes and on the date stated above.

22a. SIGNATURE: Edward S Beck M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Edward S. Beck, Md.

22d. ADDRESS: Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/16/66

23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

23d. LOCATION (City or Town) (County) (State): Annapolis, AA Md.

24. FUNERAL DIRECTOR: Beverley E. Hopping — ADDRESS: Hopping Funeral Home - Annapolis, Md. — Beverley E Hopping

25a. REC'D BY REGISTRAR DATE: NOV 16 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

15102

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15104 Item 7 Film G382 11/21/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15104

1. PLACE OF DEATH
   a. COUNTY: A.A. Co. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Glen Burnie
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): D.O.A. North Arundel.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MD
   b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Baltimore. 30.4
   d. STREET ADDRESS: 1213 Hollins Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: E — Last: McKenzie

4. DATE OF DEATH: Month: Nov — Day: 9 — Year: 19 66

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-15-20

9. AGE (In years last birthday): 46 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Tote Lady

10b. KIND OF BUSINESS OR INDUSTRY: Casmento Co.

11. BIRTHPLACE (State or foreign country): Lynchburg, Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Clay Evans

14. MOTHER'S MAIDEN NAME: Anna Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: W. L. Evans, Brother — Address: Severna Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Myocardial Infarction
   DUE TO (b): Asthma
   DUE TO (c):
   Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
   241 X
   INTERVAL BETWEEN ONSET AND DEATH: Sudden

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): E. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: NOV 9-66

23a. BURIAL, CREMATION, REMOVAL (Specify): removal

23b. DATE THEREOF: 11/12/66

23c. NAME OF CEMETERY OR CREMATORY: Fairhill Memorial Pk

23d. LOCATION (City or Town) (County) (State): Lynchburg, Va.

24. FUNERAL DIRECTOR: Catherine M. Barranco — ADDRESS: Severna Park, Md.

25a. REC'D BY REGISTRAR DATE: NOV 14 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V8. A15ME
5M 2/57

15105

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 15105

1. PLACE OF DEATH
a. COUNTY AACO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A - Anne Arundel. Gen

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD — b. COUNTY AACO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastleigh Hgts 02.1
d. STREET ADDRESS Rt 2 - Box 396
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

99

3. NAME OF DECEASED (Type or print): First Rachel — Middle F — Last Manigan
4. DATE OF DEATH: Month 11 — Day 11 — Year 1966
5. SEX: F
6. COLOR OR RACE: N
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-7-1915
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Union, S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andy Manigan
14. MOTHER'S MAIDEN NAME: Winnie Manigan

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: UNK.
17. INFORMANT: Christine Miller — Address: Earleigh Hgts, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour — Month, Day, Year — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): E Linhardt.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11-11-66

2

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11-17-66
22c. NAME OF CEMETERY OR CREMATORY: Union Cem.
22d. LOCATION (City, town, or county) (State): Union, S.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Morton + Dyett — ADDRESS: 1701 Laurens St.
24a. REC'D BY REGISTRAR DATE: NOV 14 1966
24b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15106

CERTIFICATE OF DEATH

15106

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 26 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 30.4
d. STREET ADDRESS: 1613 Caroline Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): #16395 — First: Paul — Middle: — Last: March

4. DATE OF DEATH: Month: 11/ — Day: 28 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 7/11/1934

9. AGE (In years last birthday): 32 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Carrington March

14. MOTHER'S MAIDEN NAME: Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Peritonitis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Perforation of Upper third of Jejunum
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
5 78X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Mental Deficiency

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. ---------- 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/27/ , 1940 , to 11/28/ , 1966, that (I) (we) last saw the deceased alive on 11/28/ 1966, and that death occurred at 11:□M from causes and on the date stated above.

22a. SIGNATURE: Hildegard Heard Reis M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR A. ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/28/66

22c. PHYSICIAN'S NAME (Type): Hildegard Heard Reissman

22d. ADDRESS: Crownsville State Hospital, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/2/66

23c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.

23d. LOCATION (City or Town) (County) (State): Ann Arundel County Md.

24. FUNERAL DIRECTOR: WM. C. MARCH — ADDRESS: 928 E. North Ave

25a. REC'D BY REGISTRAR DATE: DEC 1 1966

25b. REGISTRAR'S SIGNATURE: [illegible]

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15107

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15107

1. **PLACE OF DEATH**
   a. COUNTY: A. A. Co. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: AACO
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena 021
   d. STREET ADDRESS: RFD #1 - Riverside Dr - Pasadena
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Richard — Middle: Marlow — Last:

4. **DATE OF DEATH**: Month: 11 — Day: 13 — Year: 19 66

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/17/89

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNKNOWN

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): UNKNOWN

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 216-10-8606

17. **INFORMANT** Address: Welfare Records - Annapolis, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerosis generalized — INTERVAL BETWEEN ONSET AND DEATH: 21 days.
DUE TO: Renal insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Malnutrition
DUE TO
(c): Alcoholism chronic
260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture femur left

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☑ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): Fell at home

20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m.: Oct 19 66

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): AACO MD

21. **I certify** that I taak charge of the remains described abave, held an Autapsy ☐, Inspectian ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt M.D.

EXAMINER'S NAME (Type): E. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

Address (Street, city, town, or county):

22. DATE SIGNED: 11/13/66.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 11/15/66

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d. LOCATION (City or Town) (County) (State): Washington D.C.

24. FUNERAL DIRECTOR ADDRESS: Bentley E. Hopping — Hopping Funeral Home / Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: NOV 17 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15108

CERTIFICATE OF DEATH

15108

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): (Dead on arrival) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d. STREET ADDRESS: Box-282
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: Riley — Last: MARTIN

4. DATE OF DEATH: Month: November — Day: 10 — Year: 19 66

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑
8. DATE OF BIRTH: 1-20-1899
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MUSICIAN
10b. KIND OF BUSINESS OR INDUSTRY: MUSICIAN
11. BIRTHPLACE (County & State, or foreign country): Scotland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: WILLIAM MARTIN
14. MOTHER'S MAIDEN NAME: HELEN MOFFOTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 134-07-1183
17. INFORMANT: Patricia M. Poth — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Severe Aortic Stenosis & Chron. 4241
DUE TO (b): Congestive Heart failure — 4341 Sudden death.
DUE TO (c): ASCVD 4221 or Rheumatic Heart Disease 416
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221
INTERVAL BETWEEN ONSET AND DEATH: (a) Minutes. (b) 5 years. (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~XXXXXXX~~) attended the deceased from March, 1966, to Nov., 1966, that (I) (~~XXX~~) last saw the deceased alive on 11-7- 19 66 and that death occurred at 11:30 AM from causes and on the date stated above.

22a. SIGNATURE: Pete F. Verkouw
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-10-66
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: 1407 Forest Drive, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11-13-1966
23c. NAME OF CEMETERY OR CREMATORY: HILLCREST
23d. LOCATION (City or Town) (County) (State): ANNAPOLIS MD.

24. FUNERAL DIRECTOR ADDRESS: JOHN M. TAYLOR SONS ANNAPOLIS MD.
25a. REC'D BY REGISTRAR DATE: NOV 15 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15109 (15109)

-FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: AACo — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A.-North Arundel-Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD — b. COUNTY: AACo
c. CITY OR TOWN (If outside carporate limits, write RURAL and give neorest town): Glen Burnie 021
d. STREET ADDRESS: 103-3rd Ave S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: E — Last: Masters
4. DATE OF DEATH: Month: 11 — Day: 30 — Year: 19 66
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-12-88
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ch Store-Keeper (Ret)
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Coast Guard
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (Unknown)
14. MOTHER'S MAIDEN NAME: Masters Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): 1904-1939
16. SOCIAL SECURITY NO.: 220/18/7888
17. INFORMANT: Mrs. Nancy Davey (Daughter) — Address: Severna Park Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerosis generalized — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E Linhardt M.D.
EXAMINER'S NAME (Type): E Linhardt.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): 11.30.66.
22. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec 3, 1966
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City or Town) (County) (State): Brooklyn, R.F.D. Md.

24. FUNERAL DIRECTOR: R. V. Singleton — ADDRESS: Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE: DEC 5 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funerol director. Page 4 should be forwarded to the Chief Medicol Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and2 with the State Department of Health or its designated ogent, prior to burial, cremation, or removol, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15110

CERTIFICATE OF DEATH

15110

1. **PLACE OF DEATH**
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 21 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 612 Oakland Road

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residance before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie 02.1
d. STREET ADDRESS: 612 Oakland Road
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Maggie; Middle: May; Last: Matthews

4. **DATE OF DEATH**: Month: Nov; Day: 6; Year: 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct 7, 1882

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): Accomack County, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Bevans

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Miss Beatrice Matthews, Address: 612 Oakland Rd. Glen Burnie, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO (b): Hypertentive CV Disease
DUE TO (c): Arteriosclerosis General
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. 443X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1960, 19..., to Nov 6, 1966, that (I) (we) last saw the deceased alive on Oct 29 1966, and that death occured at 6 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Joseph Taler, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/6/66

22c. PHYSICIAN'S NAME (Type): JOSEPH TALER

22d. ADDRESS: 95 AQUAHART Rd. Glen Burnie Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-9-1966

23c. NAME OF CEMETERY OR CREMATORY: First Baptist

23d. LOCATION (City, town or county) (State): Pocomoke City, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert H. Watson
Robert H. Watson

ADDRESS: Pocomoke City, Md.

25a. REC'D BY REGISTRAR DATE: NOV 14 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15111

CERTIFICATE OF DEATH

15111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G MEADE
c. LENGTH OF STAY IN 1b: 62 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEVERN
d. STREET ADDRESS: Route #2, Box 241-A
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: GEORGIA; Middle: ELIZABETH; Last: McCARTY

4. DATE OF DEATH: Month: NOVEMBER; Day: 7; Year: 19 66

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 14 MAY 1921

9. AGE (In years last birthday): 45 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Troteman, Georgia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: G.B. Ammons

14. MOTHER'S MAIDEN NAME: Unknown Josie D. MEEKS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): N/A

16. SOCIAL SECURITY NO.: 418-12-3162

17. INFORMANT: Wm McCarty, Jr. — Address: Route #2, Box 241-A, Severn, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Esophageal Vorices	3 Months
DUE TO (b)	Laenne's Cirrhosis	1 Year
DUE TO (c)	Nutritional Cirrhosis	

5811

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from 8 Sept, 1966, to 7 Nov, 19 66 that ~~I~~ (we) last saw the deceased alive an 7 Nov 19 66, and that death occurred at 7:05a M, fram causes and an the date stated abave.

22a. SIGNATURE: Stuart H. Brager, Cpt, MC — M.D. — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22b. DATE SIGNED: 7 November 1966

22c. PHYSICIAN'S NAME (Type): STUART H. BRAGER, CPT, MC

22d. ADDRESS: KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Nov. 10, 1966

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL CEM.

23d. LOCATION (City or Town) (County) (State): ARLINGTON VIRGINIA

24. FUNERAL DIRECTOR — ADDRESS: Harold S. Wade, Laurel, Md

25a. REC'D BY REGISTRAR — DATE: NOV 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15112

CERTIFICATE OF DEATH

15112

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   d. STREET ADDRESS: 3 Murray Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Clarence — Middle: Bayne — Last: MC CRANE

4. **DATE OF DEATH**: Month: November — Day: 14 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 14, 1892

9. AGE (In years last birthday): 74 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER

10b. KIND OF BUSINESS OR INDUSTRY: U.S.N.M.C.L.

11. BIRTHPLACE (County & State, or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: JAMES J. McCRANE

14. MOTHER'S MAIDEN NAME: MARGARET JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: MRS. NELLIE M. McCRANE #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Today
   DUE TO (b): Arteriosclerotic Heart Disease — Unknown
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 8/2, 1962, to 11/14, 1966, that (I) ~~(we)~~ last saw the deceased alive on 11/14 1966, and that death occurred at ~~12:30~~ P.M. from causes and on the date stated above.

22a. SIGNATURE: Richard I. Hochman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/15/66

22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, M.D.

22d. ADDRESS: 59 Franklin St, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 11-17-1966

23c. NAME OF CEMETERY OR CREMATORY: ALL SAINTS CEM

23d. LOCATION (City or Town) (County) (State): PHILADELPHIA PA.

24. FUNERAL DIRECTOR — ADDRESS: JOHN M. TAYLOR SONS ANNAPOLIS MD.

25a. REC'D BY REGISTRAR DATE: NOV 17 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15113

CERTIFICATE OF DEATH

15113

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairhaven 02-1
d. STREET ADDRESS: Rt. 1, Box 258
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: Henry — Last: MITCHELL

4. DATE OF DEATH: Month: November — Day: 2 — Year: 19 66

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 13, 1917
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Cornelius Mitchel
14. MOTHER'S MAIDEN NAME: Maggie Reid

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 216-285163
17. INFORMANT: Address: Isabel Mitchel. Fairhaven- Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Hypertensive cardio-vascular disease — unknown
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 29, 19 66, to Nov. 2, 19 66, that (I) (we) last saw the deceased alive on Nov. 2 1966, and that death occurred at 5:02 P.M. from causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/2/66
22c. PHYSICIAN'S NAME (Type): Willard F. Smith MD
22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 11-6-66
23c. NAME OF CEMETERY OR CREMATORY: MOses Cem.
23d. LOCATION (City or Town) (County) (State): A.A. Co. Md.

24. FUNERAL DIRECTOR: Pinkney E. Sewell — ADDRESS: Prince Frederick-Md
25a. REC'D BY REGISTRAR DATE: NOV 7 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15114 **CERTIFICATE OF DEATH** 15114

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Laurel Acres

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 402 E. Cross Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Thomas — Last: Moon

4. DATE OF DEATH: Month: 11 — Day: 27 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 20, 1890

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dockhand 1St Cl.

10b. KIND OF BUSINESS OR INDUSTRY: Beth. Steel Co.

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William T. Moon

14. MOTHER'S MAIDEN NAME: Mary E. Anthony

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 215-09-4552

17. INFORMANT: Family — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Arterio sclerotic heart disease — 6years
DUE TO (c): 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus-----5 years

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/3/61, 19__, to 11/27/66, 19__, that (I) (we) last saw the deceased alive on 11/25/66 19__, and that death occurred at __M, from the causes and on the date stated above.

22a. SIGNATURE: Harry Deibel M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/28/66

22c. PHYSICIAN'S NAME (Type): Harry Deibel, Md

22d. ADDRESS: 1226 S. Hanover St., Baltimore 30, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11 30 1966

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

23d. LOCATION (City, town or county) (State): Brooklyn, A. A. Co. Md.

24. FUNERAL DIRECTOR — ADDRESS: McCully Funeral Home, 130 E. Fort Ave. ,Balto.Md

25a. REC'D BY REGISTRAR — DATE: NOV 30 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15115

CERTIFICATE OF DEATH

15115

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M S-63

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
   c. LENGTH OF STAY IN 1b: 3 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Box 132, Rte. 5

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md.
   b. COUNTY: AA
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena 021
   d. STREET ADDRESS: Box 132, Rte. 5
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Mario — Middle: V. — Last: Moscatelli

4. **DATE OF DEATH**: Month: November — Day: 21 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8 May 1913

9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager

10b. KIND OF BUSINESS OR INDUSTRY: General Electric

11. BIRTHPLACE (County & State, or foreign country): Rome, Italy

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 019-10-2379

17. INFORMANT — Address: Lois F. Moscatelli, wife, same as 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from June, 1961, to Nov 21, 1966, that (I) ~~(we)~~ last saw the deceased alive on Nov 7 1966, and that death occurred at 1 A.M, from the causes and on the date stated above.

22a. SIGNATURE: Charles E Shaw M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 21 Nov. 1966

22c. PHYSICIAN'S NAME (Type): Charles Shaw, M. D.

22d. ADDRESS: 607 W. Joppa Road, Baltimore, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 23 Nov. 1966

23c. NAME OF CEMETERY OR CREMATORY: Dulaney Valley

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.

25a. REC'D BY REGISTRAR — DATE: NOV 23 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15116

CERTIFICATE OF DEATH

15116

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): N. Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 8 Eighth Ave., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AUGUSTA — Middle G. — Last MURR
4. DATE OF DEATH: Month November — Day 3 — Year 1966
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 12, 1884
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Lady
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Joseph Murr
14. MOTHER'S MAIDEN NAME: Anna Schmidt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No
16. SOCIAL SECURITY NO.: 214-03-0666
17. INFORMANT: Jerome G. Wagner — Address: 8 Eighth Ave., N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Failure
151X
DUE TO
(b): Carcinoma of Stomach & metastasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospitol) attended the deceased from Jan, 19 66 to 11/3, 1966, that (I) (~~we~~) last saw the deceased alive on 11-3 1966, and that death occurred at 9:55 P.M., from couses and on the dotе stated above.

22a. SIGNATURE: Wayne B. Tate M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: November 4, 1966
22c. PHYSICIAN'S NAME (Type): WAYNE B. TATE, M.D.
22d. ADDRESS: 108 Central Ave., Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 7, 1966
23c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery
23d. LOCATION (City or Town) (County) (State): Ritchie Hgwy., A.A.Co., Md.

24. FUNERAL DIRECTOR: George J. Gonce — ADDRESS: 4001 Ritchie Hgwy., Baltimore
25a. REC'D BY REGISTRAR DATE: NOV 7 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15117 **CERTIFICATE OF DEATH** 15117

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Aruhdel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): RURAL - Annapolis
d. STREET ADDRESS: Rt-1, Box-538
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Lillian — Middle Mae — Lost NALLEY

4. DATE OF DEATH: Month November — Doy 1 — Year 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 24, 1882
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (County & Stote, or foreign country): MITCHELLVILLE Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: GEORGE BEALL
14. MOTHER'S MAIDEN NAME: LEVINIA ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give wor or dotes of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: EDMUND F. NALLEY — Address: IGLEHART A.A.CO MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Coronary occlusion — unknown
DUE TO (c): Arteriosclerosis
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from ____, 19____, to Nov. 1, 1966, that (I) (~~not~~) last saw the deceased alive an Nov. 1, 1966, and that death occurred at 11:30 AM, from causes and on the date stated above.

22a. SIGNATURE: Ray M Smith M.D.
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/1/66
22c. PHYSICIAN'S NAME (Type): RAY M SMITH M.D.
22d. ADDRESS: Severna Park Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11-4-1966
23c. NAME OF CEMETERY OR CREMATORY: WHITEMARSH CEM
23d. LOCATION (City or Town) (County) (State): PRI. GEORGE Co MD.

24. FUNERAL DIRECTOR: JOHN M. TAYLOR SONS — ADDRESS: ANNAPOLIS MD
25a. REC'D BY REGISTRAR — DATE NOV 4 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the deoth certificate be executed within 24 hours after death. Page 4 may be retoined by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Stote Dept. of Health prior to buriol, cremotion, or removal, and in any event, within 72 hours after deoth.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15118

CERTIFICATE OF DEATH

15118

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Magothy Beach
c. LENGTH OF STAY IN 1b: 7 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ~~xxxxxx~~ Rt. 5, Box 233A, Pasadena, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena, Md. 21
d. STREET ADDRESS: Riverside Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Henry — Last: Neff

4. DATE OF DEATH: Month: November — Day: 17 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 25, 1906

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Burning + welding

10b. KIND OF BUSINESS OR INDUSTRY: Maryland Drydock

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew Neff

14. MOTHER'S MAIDEN NAME: Anna Fay

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 212-07-1716

17. INFORMANT: Mrs James Neff — Address: Pasadena, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the left lung — INTERVAL BETWEEN ONSET AND DEATH: 1 year

163X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Pulmonary Hemorrhage — 20 minutes
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from September 15, 1966, to Nov 17, 1966, that (I) (we) last saw the deceased alive on Nov 17 1966, and that death occurred at 11 A M, from the causes and on the date stated above.

22a. SIGNATURE: R.M. McLaughlin — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/17/66

22c. PHYSICIAN'S NAME (Type): R.M. McLaughlin, M.D.

22d. ADDRESS: 3708 Mountain Rd. Pasadena, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 21, 1966

23c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery

23d. LOCATION (City, town or county) (State): Ritchie Hgwy., A.A.Co., Maryland

24. FUNERAL DIRECTOR — ADDRESS: George J. Gonce — 4001 Ritchie Hgwy., Baltimore

25a. REC'D BY REGISTRAR — DATE: NOV 23 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

15119

CERTIFICATE OF DEATH

Reg. Dist. No. 15119

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Greenland Beach
c. LENGTH OF STAY IN 1b: 10 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: 202 Greenland Beach Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Greenland Beach
d. STREET ADDRESS: 202 Greenland Beach Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

02-1

3. NAME OF DECEASED (Type or print): First ELEANOR Middle M. Last O'BROCKIE

4. DATE OF DEATH: Month 11 Day 20 Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 25, 1907

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John R. Stein

14. MOTHER'S MAIDEN NAME: Katherine Patterson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Charles J. O'Brockie - same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MULTIPLE SCLEROSIS — 345 x — INTERVAL BETWEEN ONSET AND DEATH: 9 YEARS
DUE TO
Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Manth, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/18, 1957, to 11/20, 1966, that I last saw the deceased alive on 11/1, 1966, and that death occurred at 9:25A M, from the causes and an the date stated above.

ACTUAL SIGNATURE: J. Brady Smith M.D. — ADDRESS (Street, city or town, state): 8471 Ft. Smallwood Road — DATE SIGNED: 11/21/66

PHYSICIAN'S NAME (Type): J. BRADY SMITH — Pasadena, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-23-1966

22c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery

22d. LOCATION (City, town, or county) (State): Ritchie Hgwy., A.A.Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: George J. Gonce-4001 Ritchie Hgwy., Baltimore

24a. REC'D BY REGISTRAR DATE: NOV 25 1966

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15120 **CERTIFICATE OF DEATH** 15120

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 12 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ANNE ARUNDEL GENERAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TRACY'S LANDING
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SARAH Middle ELLEN Last OWENS

4. DATE OF DEATH: Month 11 Day 12 Year 1966

5. SEX: F

6. COLOR OR RACE: N

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-1-91

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): ANNE ARUNDEL County Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: BROWN JOHN

14. MOTHER'S MAIDEN NAME: ANNE CONWAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: WILLIAM [illegible] OWENS Address: Harwood SON

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CACHEXIA
DUE TO (b): TERMINAL STAGE LEIOMYOSARCOMA, RETROPERITONEAL SPACE
DUE TO (c): —
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse lost.
1979
INTERVAL BETWEEN ONSET AND DEATH: 6 MONTHS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ASCITES, ANEMIA, ASHD Chronic Urinary tract infection

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-1, 1966, to 11-12, 1966, that (I) (we) last saw the deceased alive on 11-12 1966 and that death occurred at 9:50 M, from causes and on the date stated above.

22a. SIGNATURE: Martin T. Kim M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-12-66

22c. PHYSICIAN'S NAME (Type): MARTIN T. KIM. M.D.

22d. ADDRESS: SHADY SIDE, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 11-16-66

23c. NAME OF CEMETERY OR CREMATORY: Union Chapel Cem

23d. LOCATION (City or Town) (County) (State): Tracys AA Md

24. FUNERAL DIRECTOR: Aubrey E. Sewell ADDRESS: Prince Frederick Md.

25a. REC'D BY REGISTRAR DATE: NOV 17 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours of ter death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15121

CERTIFICATE OF DEATH

15121

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn): Pasadena 02.1
   d. STREET ADDRESS: Box 246 B, Rt. 9
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Eleanor — Middle: Miller — Lost: PEARMAN

4. **DATE OF DEATH**: Month: November — Doy: 6 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 5, 1897

9. AGE (In yeors last birthday): 69 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & Stote, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Richard Miller

14. MOTHER'S MAIDEN NAME: Clara Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Bertha Fisher Box 246 Rt 9 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
DUE TO
(b): Arteriosclerotic Heart Disease — Unknown
DUE TO
(c):
Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse lost.
4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 6/9, 1963, to 11/6, 1966, that (I) ~~(we)~~ last saw the deceased alive on 11/6 1966, and that death occurred at 9:10 P.M. from causes and on the date stated obave.

22a. SIGNATURE: Richard I. Hochman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/7/66

22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, M.D.

22d. ADDRESS: 59 Franklin St, Annapolis, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-10-66

23c. NAME OF CEMETERY OR CREMATORY: Hall's Methodist Church Yard

23d. LOCATION (City or Town) (County) (State): Anne Arundel Md

24. FUNERAL DIRECTOR — ADDRESS: Isaiah L. Brown and Son-108-W. Momtgomery St

25a. REC'D BY REGISTRAR DATE: NOV 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15122

CERTIFICATE OF DEATH

15122

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: ////
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie 02.1
d. STREET ADDRESS: #105 Chestnut Lane N/W
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lucy — Middle: Louise — Last: Petticrew

4. DATE OF DEATH: Month: November — Day: 21, — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 6, 1912

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Huffman

14. MOTHER'S MAIDEN NAME: Lulu Heaton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 301-09-9170

17. INFORMANT — Address: Mr. James M. Petticrew (Husband) Same as#2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO (b): Chronic Myocardial Failure — 3 yrs
DUE TO (c): Cor Pulmonale — 5 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
43-44

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchiectasis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-24, 1966, to 11-21, 1966, that (I) (we) last saw the deceased alive on 11-19 1966, and that death occurred at 8 P M, from causes and on the date stated above.

22a. SIGNATURE: M W Jacobson — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-22-66

22c. PHYSICIAN'S NAME (Type): M.W. WACOBSON M.D

22d. ADDRESS: 6821 Reisterstown Rd Balt 15

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 25, 1966

23c. NAME OF CEMETERY OR CREMATORY: Forncliff Cemetery

23d. LOCATION (City or Town) (County) (State): Springfield Ohio

24. FUNERAL DIRECTOR: Richard V. Singleton — ADDRESS: Glen Burnie, Md.

25a. REC'D BY REGISTRAR — DATE: NOV 23 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15123

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15123

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 311 Columbus Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Raymond Middle Last PITTS
4. DATE OF DEATH Month NOV. Day 7 Year 1966
5. SEX Male
6. COLOR OR RACE Colored
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3/27/37
9. AGE (In years last birthday) 29 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME JAMES PITTS
14. MOTHER'S MAIDEN NAME ANNIE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Mrs Rose Pitts 311 Columbus Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
974X
IMMEDIATE CAUSE (a) HANGING
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hung Self in Jail Cell of Ferndale police Station
20c. TIME OF INJURY Month, Day, Year Hour 6:00 a.m. (p.m.) 11/7/1966
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jail
20f. (City or town) Ferndale (County) AA (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz M.D.
EXAMINER'S NAME (Type) Werner U. Spitz, M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)
22. DATE SIGNED Nov 8th 1966

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 11/11/66
23c. NAME OF CEMETERY OR CREMATORY Mt Calvary
23d. LOCATION (City or Town) A A (County) COUNTY (State) MD

24. FUNERAL DIRECTOR ADOLPHUS HALSTEAD
ADDRESS 1206 W North Ave
25a. REC'D BY REGISTRAR DATE NOV 14 1966
25b. REGISTRAR'S SIGNATURE J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15124

CERTIFICATE OF DEATH

15124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: 4days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): N. Arundel Hosp.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville 1201
   d. STREET ADDRESS: Brookwood Rd.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: William — Middle: Floyd — Last: Price, Sr.

4. **DATE OF DEATH**: Month: November — Day: 6, — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 22, 1905

9. AGE (In years last birthday): 60 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bank Empolyee

10b. KIND OF BUSINESS OR INDUSTRY: Md. Nat'l Bank

11. BIRTHPLACE (County & State, or foreign country): Berkeley Springs W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William L. Price

14. MOTHER'S MAIDEN NAME: Josephine Gibbs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 214-05-4194

17. **INFORMANT** Address: Mrs. Gayle Price (wife) Same As #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
   4201
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b)
   DUE TO
   (c)

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Metastatic Carcinoma of Rectum 154

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August, 19 63, to November, 1966, that (I) (we) last saw the deceased alive on Nov. 6, 19 66, and that death occurred at 2:13 PM from causes and on the date stated above.

22a. SIGNATURE: C. R. MacDonald MD — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Nov. 7, 1966

22c. PHYSICIAN'S NAME (Type): C. R. Mac Donald M.D.

22d. ADDRESS: 204 Crain Hwy. S/W Glen Burnie, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 9, 1966

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City or Town) (County) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR: Eugene B. Mooney — ADDRESS: Singleton Funeral Home, Glen Burnie, Maryland

25a. REC'D BY REGISTRAR DATE: NOV 9 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15125

CERTIFICATE OF DEATH

15125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: ANNE ARUNDEL — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEORGE G MEADE c. LENGTH OF STAY IN 1b: 5 HOURS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ODENTON 02.1 d. STREET ADDRESS: RT 1 BOX 307 BUCKLINA e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
CALLISTA	V	PROSEY	NOVEMBER	8	19 66

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
FEMALE	CAU		25 DEC 14	51 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	-	BALTIMORE MD	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
EARL FRANTON	CALLISTA FITZPATRICK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	218-18-4611 UNKNOWN	JACK D PROSEY SAME AS 2D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	METASTATIC CARCINCOMA OF LUNG	4 MONTHS
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	BREAST CARCINOMA	3 YEARS
DUE TO (c)		

1 70 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 8 NOV, 1966, to 8 NOV, 1966, that ☒ (we) last saw the deceased alive on 8 NOV 19 66, and that death occurred at 1105 PM, from causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22b. DATE SIGNED
Donald E Parlee					9 NOV 66

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
DONALD E PARLEE, CAPT, MD	KIMBROUGH ARMY HOSPITAL

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov.11,1966	Epiphany Episcopal Ch.Cem.	Odenton A.A. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Beverley E. Hopping HOPPING FUNERAL HOME	Annapolis, Md.	NOV 14 1966	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15126

CERTIFICATE OF DEATH

15126

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): RURAL - Pasadena
d. STREET ADDRESS: Rt. 1, Box 66B
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Michael — Middle: Paul — Last: RASPA

4. DATE OF DEATH: Month: November — Day: 8 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 23, 1921

9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber

10b. KIND OF BUSINESS OR INDUSTRY: Plumbing & Heating

11. BIRTHPLACE (County & State, or foreign country): BaltimoreMaryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frank Raspa

14. MOTHER'S MAIDEN NAME: Angelin Montiferenti

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): WW 11

16. SOCIAL SECURITY NO.: 216-12-3439

17. INFORMANT — Address: Mrs. Gertrude Raspa, same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute renal failure
603 X
DUE TO
(b): Renal Tubular Necrosis
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~his knowledge~~) attended the deceased from Oct. 23, 1966 to Nov. 8, 1966, that (I) (XX) last saw the deceased alive on Nov. 8 19 66, and that death occurred at 5:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: Edwin Davis, Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/9/66

22c. PHYSICIAN'S NAME (Type): Edwin Davis, Jr. M.D.

22d. ADDRESS: 100 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12 Nov. 1966

23c. NAME OF CEMETERY OR CREMATORY: Holy Rosary Cemetery

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR — ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: NOV 14 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15127

CERTIFICATE OF DEATH

15127

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits; write RURAL and give nearest town): FT GEORGE G MEADE
c. LENGTH OF STAY IN 1b: 10 hrs 54 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT GEORGE G. MEADE
d. STREET ADDRESS: 7229-F HALL STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MICHAEL — Middle INFANT N. — Last TYRONE RIVERS

4. DATE OF DEATH: Month NOV — Day 2 — Year 1966

5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2 NOVEMBER 66
9. AGE (In years lost birthday): yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 10 / Min. 54

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A
10b. KIND OF BUSINESS OR INDUSTRY: N/A
11. BIRTHPLACE (County & State, or foreign country): ANNE ARUNDEL, MARYLAND
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: WALTER RIVERS
14. MOTHER'S MAIDEN NAME: MARVA COOPER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): N/A
16. SOCIAL SECURITY NO.: N/A
17. INFORMANT — Address: WALTER RIVERS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Distress Syndrome
DUE TO (b): Associated c prematurity
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7735
INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7:30 PM 2 NOV, 19 66, to 11 PM 2 NOV, 19 66, that (I) (we) last saw the deceased alive on 2 NOV 1966, and that death occurred at 10:55 PM, from causes and on the date stated above.

22a. SIGNATURE: Robert F. Cullen Jr. M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 3 Nov. 66
22c. PHYSICIAN'S NAME (Type): ROBERT F. CULLEN, CPT, MC
22d. ADDRESS: Kimbrough Army Hosp, Ft Geo G. Meade, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: NOV. 7, 1966
23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL CEM.
23d. LOCATION (City or Town) (County) (State): ARLINGTON, VIRGINIA

24. FUNERAL DIRECTOR: Harold S. Wade — ADDRESS: 550 Main Blvd Laurel, Md
25a. REC'D BY REGISTRAR — DATE: NOV 28 1966
25b. REGISTRAR'S SIGNATURE

6-237566

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15128 15128

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): North Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 3523 Chesterfield Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Thelma — Middle M. — Last Roberson
4. DATE OF DEATH: Month November — Day 18, — Year 19 66
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 23, 1926
9. AGE (In years last birthday): 40 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): seamstress
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Lawerence Smith
14. MOTHER'S MAIDEN NAME: Ethel, Watson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Marlan Roberson — Address: as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Heart Failure — (INTERVAL BETWEEN ONSET AND DEATH)
241X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Severe Asthma — Cor-Pulmale —
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/9, 1966, to ____, 19____, that (I) (we) last saw the deceased alive on 11/16 19 66, and that death occurred at ____M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/19/66
22c. PHYSICIAN'S NAME (Type): DR. E. M. RAMOS
22d. ADDRESS: 3927 Annapolis Rd —

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/21/66
23c. NAME OF CEMETERY OR CREMATORY: Moreland memorial
23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: William J. Tichnor & Sons
ADDRESS: North & Payson
25a. REC'D BY REGISTRAR DATE: NOV 21 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15129

CERTIFICATE OF DEATH

15129

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CROWNSVILLE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BOX 148, Route #1

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CROWNSVILLE 02.1
d. STREET ADDRESS: BOX 148, Route #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle (NMI) — Last ROMANOS

4. DATE OF DEATH: Month NOVEMBER — Day 12 — Year 19 66

5. SEX: MALE

6. COLOR OR RACE: CAUC

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1 AUG 1888

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer

10b. KIND OF BUSINESS OR INDUSTRY: Law

11. BIRTHPLACE (County & State, or foreign country): Taganrog, Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Irines Romanos

14. MOTHER'S MAIDEN NAME: Sotisa Hazardji

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): N/A
(If yes give war or dates of service): N/A

16. SOCIAL SECURITY NO.: 217-56-3481

17. INFORMANT: Mrs. Xenia M.Jelich, Box 148, Route #1 — Address: Crownsville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probably, acute myocardial infarction
4201
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that [redacted] the deceased [redacted] WAS DOA, [redacted], 12 NOV, 1966, [redacted] 19[redacted], and that death occurred at 8:15 M, from causes and on the date stated above.

22a. SIGNATURE: N. A. Robinson M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 12 NOV 66

22c. PHYSICIAN'S NAME (Type): NEIL A. ROBINSON, CPT, MC

22d. ADDRESS: KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Nov. 15, 1966

23c. NAME OF CEMETERY OR CREMATORY: St. Stephens Church Cemetery, Millersville, Maryland

23d. LOCATION (City or Town) (County) (State)

24. FUNERAL DIRECTOR: Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland

ADDRESS

25a. RECD BY REGISTRAR DATE: NOV 15 1966

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15130

CERTIFICATE OF DEATH

16584

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
   c. LENGTH OF STAY IN 1b: 3 mths
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Ohio — b. COUNTY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cleveland 12.3
   d. STREET ADDRESS: 819 Eddy Rd
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Abe — Middle — Last: Sacheroff

4. DATE OF DEATH: Month: Nov. — Day: 27th — Year: 1966

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/10/97

9. AGE (In years last birthday): 69 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Max Sacheroff.

14. MOTHER'S MAIDEN NAME: Mollie.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Hospital Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH
463X
DUE TO (b): Phlebothrombosis of lower extremities -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/16, 1966, to 11/27, 1966, that (I) (we) last saw the deceased alive on 11/27 1966, and that death occurred at 4:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: Alvin Thompson M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11/27/66.

22c. PHYSICIAN'S NAME (Type): Alvin Thompson

22d. ADDRESS: Crownsville State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE THEREOF: 12/20/66

23c. NAME OF CEMETERY OR CREMATORY: UNIVERSITY Md

23d. LOCATION (City or Town) (County) (State): BALT, Md

24. FUNERAL DIRECTOR — ADDRESS: Annapolis, Maryland
William Reese II 108 W. Washington St.

25a. REC'D BY REGISTRAR — DATE: DEC 22 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15131

CERTIFICATE OF DEATH

15130

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shadyside
d. STREET ADDRESS: 02-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard — Middle: Thomas — Last: SCOTT

4. DATE OF DEATH: Month: November — Day: 30 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 22, 1892

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Richard Scott

14. MOTHER'S MAIDEN NAME: Jeanet Grayson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): yes WWI

16. SOCIAL SECURITY NO.: 218-16-3331

17. INFORMANT: Rachel Wicks — Address: Shadyside Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal pneumonia — INTERVAL BETWEEN ONSET AND DEATH: one week
DUE TO (b): Cerebral Thrombosis c rt. hemiplegia & aphasia — one month
DUE TO (c): Cerebral arteriosclerosis — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 002.1 Pulmonary Tuberculosis, arrested

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 1960, to Nov. 30, 1966, that (I) (we) last saw the deceased alive on Nov. 29 1966, and that death occurred at (9:30 A.M.) from causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/30/66

22c. PHYSICIAN'S NAME (Type): Willard F. Smith, MD

22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-3-1966

23c. NAME OF CEMETERY OR CREMATORY: St. Matthews

23d. LOCATION (City or Town) (County) (State): Shadyside Md

24. FUNERAL DIRECTOR: William Reese — ADDRESS: Annapolis Md

25a. REC'D BY REGISTRAR DATE: DEC 2 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15132

CERTIFICATE OF DEATH

15131

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If so, please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 Hours after) death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital	d. STREET ADDRESS: 826 Boucher Ave. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
William	B.	SEGELKEN	November	12	19 66

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White		February 21, 1897	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CIVIL SERVICE	USMEL	ANNAPOLIS MD.	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
FREDERICK SEGELKEN	MARY E. VOGT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
YES	WW I		MARTHA E. SEGELKEN #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uremia	5 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Acute Pulmonary Edema,	3 wks
DUE TO (c)	Myocardial Infarction	3 wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): B.P.H.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan, 1965, to 11-12, 1966, that (I) (we) last saw the deceased alive on 11-14 1966, and that death occurred at 12:15 A.M. from causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
Frank M Shipley					11-12-66

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
F M SHIPLEY	Annapolis, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	11-15-66	CEDAR Bluff	ANNAPOLIS A.A. MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John M. Taylor & Sons Annapolis, Md	NOV 17 1966	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15133

CERTIFICATE OF DEATH

15132

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): (Dead on arrival) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 29 Shaw St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Marie — Last: SHARPS
4. DATE OF DEATH: Month: November — Day: 15 — Year: 19 66

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 24, 1924
9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Daniel Owens
14. MOTHER'S MAIDEN NAME: Marie Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Nathaniel Franklin — Address: 24 Slade

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO
(b): Mitral valve insufficiency — 7 years
DUE TO
(c): Rheumatic fever (?) — unknown
410 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension, diabetes mellitus, diabetic nephrosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~personally~~) attended the deceased from 18 Feb. , 19 66 , to 15 Nov. , 1966 , that (I) (We) last saw the deceased alive on 8 Nov. 1966 , and that death occurred at 7:50 AM M, from causes and on the date stated above.

22a. SIGNATURE: Charles W. Kinzer M.D. — ATTENDING PHYS. XX — MED. DIRECTOR ☐ — STAFF PHYS. ☐
22b. DATE SIGNED: 16 Nov. 1966
22c. PHYSICIAN'S NAME (Type): Charles W. Kinzer, M.D.
22d. ADDRESS: SouthRivMedCent., Eggewater, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-18-1966
23c. NAME OF CEMETERY OR CREMATORY: Moses
23d. LOCATION (City or Town) (County) (State): Drury Md.

24. FUNERAL DIRECTOR: William Reese — ADDRESS: Annapolis Md.
25a. REC'D BY REGISTRAR DATE: NOV 17 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit; then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15134 — 15133

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M 5-63

1. PLACE OF DEATH
a. COUNTY: A A Co. — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 2 mos
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Penna
b. COUNTY: Lancaster
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): East Earl R.D. 1 — 15-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hector — Middle: — Last: Smith

4. DATE OF DEATH: Month: Nov — Day: 1 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Nov 5 1876

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager

10b. KIND OF BUSINESS OR INDUSTRY: Golf

11. BIRTHPLACE (County & State, or foreign country): Scotland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Smith

14. MOTHER'S MAIDEN NAME: Jean Patterson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 168-01-9906

17. INFORMANT Address: Miss Lucy Hunter, 15 Cornhill St., Annapolis, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: unknown

4200

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerosis

DUE TO (c): Senility

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 10-27, 1966 to 11-1, 1966, that (I) ~~(we)~~ last saw the deceased alive on 10-31, 1966, and that death occurred at 6:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: W. P. Stephens M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-1-66

22c. PHYSICIAN'S NAME (Type): W. P. STEPHENS

22d. ADDRESS: Annapolis Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Buried

23b. DATE THEREOF: Nov 4, 1966

23c. NAME OF CEMETERY OR CREMATORY: Cedar Grove

23d. LOCATION (City, town or county) (State): East Earl, Penn

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Thomas Hardesty, Annapolis, Md

25a. REC'D BY REGISTRAR DATE: NOV 3 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15135

CERTIFICATE OF DEATH

15134

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade c. LENGTH OF STAY IN 1b: 23 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kimbrough Army Hospital	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville d. STREET ADDRESS: 98 Waterbury Rd. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First IRENE — Middle JONES — Last SMITH	4. DATE OF DEATH: Month November — Day 5 — Year 19 66
5. SEX: Female — 6. COLOR OR RACE: Negro — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 23 June 1920 — 9. AGE (In years last birthday): 46 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse 10b. KIND OF BUSINESS OR INDUSTRY: Hospital 11. BIRTHPLACE (County & State, or foreign country): Anne Arundel, Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: James H. Jones 14. MOTHER'S MAIDEN NAME: Mary C. Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): n/a 16. SOCIAL SECURITY NO.: 213-22-2244 17. INFORMANT: Jim Smith (Husband) — Address: Crownsville, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary Congestion	
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Advanced Metastatic Cancer	
DUE TO		
(c)	Cancer of Breast	1959-Pres.

170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Not Applicable

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11 October, 1966 to 5 November 19 66, that ☒ (we) last saw the deceased alive on 5 November 19 66, and that death occurred at 03:30 p.m. from causes and on the date stated above.

22a. SIGNATURE: Burton A. Johnson, Capt MC — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 5 November 1966

22c. PHYSICIAN'S NAME (Type): BURTON A. JOHNSON, CAPT, MC — 22d. ADDRESS: KIMBROUGH ARMY HOSPITAL, FGGM, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11-8-1966	John Wesley	Waterbury Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Reese Funeral Home	Annapolis, Md	NOV 7 1966	J Charles Judge

19139

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15136 — 15135

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. PLACE OF DEATH
a. COUNTY: A-A Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
c. LENGTH OF STAY IN 1b: 59 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 701 Old County Rd.

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: Md
b. COUNTY: A-A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park — 021
d. STREET ADDRESS: 701 Old County Rd.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
DAVID	F.	STEWART	11	9	1966

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE		3-7-07	59 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
OFFICER of CORP.	WOOD PRODUCTS	MARYLAND, A.A.Co	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOSEPH S. STEWART	SUE FETTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	215 09 0517	HILDA STEWART — ABOVE

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the Lung — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 19 66, to Nov 7, 1966, that (I) (we) last saw the deceased alive on Nov 11 1966, and that death occured at 8:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Gene D. Trentin M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/9/66
22c. PHYSICIAN'S NAME (Type): GENE D TRENTIN
22d. ADDRESS: 98 Cathedral St. Annapolis, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Cremation	11-11-66	Ft. Crematory	Washington D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert S. Barranco — ADDRESS: Severna Park, Md
ROBERT S. BARRANCO

25a. REC'D BY REGISTRAR DATE: NOV 14 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15137 — 15136

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: ~~Baltimore~~ Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): North Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Glen Burnie~~ Randallstown 03-1
d. STREET ADDRESS: Wards Chapel Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Herbert; Middle; Last Stubler
4. DATE OF DEATH: Month November; Day 3; Year 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-8-1905
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): communications oper.
10b. KIND OF BUSINESS OR INDUSTRY: Telephone Co.
11. BIRTHPLACE (County & State, or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Andrew Jacob Stubler
14. MOTHER'S MAIDEN NAME: Lina Schumann
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 212-03-6772
17. INFORMANT Address: Catherine Wade 615 Pamela Rd. Glen Burn

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BRONCHOGENIC CARCINOMA — INTERVAL BETWEEN ONSET AND DEATH: 5 months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
1621

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 2-7, 1948, to 11-3, 1966, that (I) (~~we~~) last saw the deceased alive on 10-28 1966, and that death occurred at 8 P. M, from causes and on the date stated above.

22a. SIGNATURE: Ken Ashman — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-4-66
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: 5907 GWYNN OAK AVE Balto. 6 Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-7-66
23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
23d. LOCATION (City or Town) (County) (State): Baltimore Maryland

24. FUNERAL DIRECTOR: Ellsworth Funeral Home
ADDRESS: 4600 Liberty Hghts. Ave.
25a. REC'D BY REGISTRAR DATE: NOV 7 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15138 15137

1. PLACE OF DEATH
a. COUNTY: Ann Arundel — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Popular Ridge
c. LENGTH OF STAY IN 1b: 12 Years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 310 Cedar Rd. Popular Ridge Pasadena, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Ann Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Popular Ridge
d. STREET ADDRESS: 310 Cedar Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ethel — Middle: A. — Last: Tegler

4. DATE OF DEATH: Month: NOV — Day: 30 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 10, 1892

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Westley Saunders

14. MOTHER'S MAIDEN NAME: Catherine ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Pasadena, Md. Address: Mr. Harry A. Tegler Popular Ridge 310 Cedar Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

(a) IMMEDIATE CAUSE: ACUTE PULMONARY OEDEMA — 48 HRS.

7100

DUE TO

(b) CHRONIC CARDIAC DECOMPENSATION — 6 MO.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c) SCLERA-DERMA — 10 YRS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): MALNUTRITION AND CACHEXIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 1958, 19..., to NOV 30, 1966, that (I) (~~we~~) last saw the deceased alive on NOV 16 1966, and that death occured at 3 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Arthur Lankford Jr. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-30-66

22c. PHYSICIAN'S NAME (Type): ARTHUR LANKFORD JR.

22d. ADDRESS: MOUNTAIN RD. PASADENA, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 3, 1966

23c. NAME OF CEMETERY OR CREMATORY: Lorraine Cem.

23d. LOCATION (City, town or county) (State): Balto. Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: G. Truman Schwab 3512 Frederick Ave. Balto. Md.

25a. REC'D BY REGISTRAR DATE: DEC 2 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

VR A15 (4)
15M 9/60

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15139

CERTIFICATE OF DEATH

15138

1. PLACE OF DEATH
a. COUNTY A.A. — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arnold
c. LENGTH OF STAY IN 1b 33 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Some Rt 1 Box 46

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md b. COUNTY A A Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold md 02-1
d. STREET ADDRESS Box 46 Rt 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Emma Middle: May Last: Thomas S.

4. DATE OF DEATH Month: 11-26-66. Day: Year: 19

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept 4, 1873

9. AGE (In years last birthday): 93 yrs.

IF UNDER 1 YEAR — Months: Days: IF UNDER 24 HRS. — Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Balto. md

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Jones Allen

14. MOTHER'S MAIDEN NAME: Laura Seagel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT Address: Margaret Ireland Huggins - Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) A.E.V.D.

DUE TO (c) General

4221

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1960, 19 to, to 1966, 19, that (I) (we) last saw the deceased alive on 11-23-66 19, and that death occurred at 7 P.M. from the causes and on the date stated above.

22a. SIGNATURE Robert R. Holm M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) Robert R. Holm

22d. ADDRESS P.O. Box 73 Severna Park

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 11/30/66

23c. NAME OF CEMETERY OR CREMATORY Glen Haven

23d. LOCATION (City, town or county) Glen Burnie (State) Md

24. FUNERAL DIRECTOR Robert S. Barranco

ADDRESS Severna Pk. Md

25a. REC'D BY REGISTRAR DATE NOV 29 1966

25b. REGISTRAR'S SIGNATURE J. Charles Judge

ROBERT S. BARRANCO

1 10726

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15140

CERTIFICATE OF DEATH

16592

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 8mos. 20 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 846 W. Baltimore St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

30.4

3. NAME OF DECEASED (Type or print): 3-#31447 — First: Andy — Middle: — Lost: Thompson
4. DATE OF DEATH: Month: 11 — Day: 24 — Year: 19 66

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May, 1893
9. AGE (In years ~~last~~ birthday): 73 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: ------
11. BIRTHPLACE (County & State, or foreign country): Norway
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Berl Thompson
14. MOTHER'S MAIDEN NAME: Tina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Pneumonia
DUE TO
(b): Arteriosclerotic Heart Disease
DUE TO
(c):
Conditions, if any, which gave rise to immediate couse (o), stating the underlying couse last.
420.0
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Emphysema, Cerebral Atherosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): --------
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. --- 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----
20f. (City or town) (County) (State): -------

21. I certify that (I) (this hospital) attended the deceased from 11/3/4, 1966 to 11/24, 1966 that (I) (we) last saw the deceased alive on 11/24 1966, and that death occurred at 1:3[illegible] M, fram causes and an the dote stated above.

22a. SIGNATURE: Hildegard Heard Reissman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/25/66
22c. PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M.D.
22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 12/21/66
23c. NAME OF CEMETERY OR CREMATORY: Univ. Md.
23d. LOCATION (City or Town) (County) (State): Balt Md.

24. FUNERAL DIRECTOR: William Reese II
ADDRESS: 108 W. Washington Street, Annapolis, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 22 1966
25b. REGISTRAR'S SIGNATURE: [illegible] Charles Yingling

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15141 — 15139

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel c. LENGTH OF STAY IN 1b: 31 yrs. 11 mos.	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C. 47-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Children's Center Hospital	d. STREET ADDRESS: 754 Harvard Street, N. W. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First MARGARET Middle Last THORNTON	4. DATE OF DEATH: Month November Day 17, Year 19 66
5. SEX: Female	6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 12-8-17
9. AGE (In years last birthday): 48 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Institutionalized	10b. KIND OF BUSINESS OR INDUSTRY: -----
11. BIRTHPLACE (County & State, or foreign country): D. C.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Thornton	14. MOTHER'S MAIDEN NAME: Maggie Hamm
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No	16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Children's Center Hospital, Laurel, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Papillary adenocarrinoma, left lung — INTERVAL BETWEEN ONSET AND DEATH: 2 years
163X
DUE TO (b): Mental retardation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Convulsive disorder

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from December 7, 1934, to Nov. 17, 1966 that (I) (we) last saw the deceased alive on Nov. 17 1966, and that death occurred at 4:23 P.M. from causes and on the date stated above.

22a. SIGNATURE: Margaret W. Mola — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Nov. 18, 1966

22c. PHYSICIAN'S NAME (Type): MARGARET W. MOLA, M.D.

22d. ADDRESS: Children's Center, Laurel, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/21/66	Children's Center	Laurel A. A. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
De Witt Donaldson	Laurel, Md	NOV 29 1966	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15142

CERTIFICATE OF DEATH

15140

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pinehurst, Pasadena
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOME: 7 Bayside Drive

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Mafyland — b. COUNTY: A. A. Co.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pinehurst, Pasadena — A2-1
   d. STREET ADDRESS: 7 Bayside Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle EDWARD — Last PURNELL TRUITT

4. DATE OF DEATH: Month 11 — Day 15 — Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 6, 1883

9. AGE (In years last birthday): 83 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED - Dentist

10b. KIND OF BUSINESS OR INDUSTRY: Dentistry

11. BIRTHPLACE (County & State, or foreign country): Snow Hill, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George W. Truitt

14. MOTHER'S MAIDEN NAME: Gertrude Purnell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
   (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 214-38-7509

17. INFORMANT: wife — Address: Pinehurst, Mrs. Margaret D. Truitt, Pasadena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Asteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: unknown
   4200
   DUE TO (b):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   DUE TO (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from May 19th, 1966, to ____, 19____, that (I) (We) last saw the deceased alive on June 1st 1966, and that death occurred at 7:30 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Hilary T. O'Herlihy M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-15-66

22c. PHYSICIAN'S NAME (Type): HILARY T. O'HERLIHY M.D.

22d. ADDRESS: 15 Central Ave, Glen Burnie

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b. DATE THEREOF: 11/17/66

23c. NAME OF CEMETERY OR CREMATORY: Green Mount Cemetery

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR — ADDRESS: Stewart & Mowen Co., 108 W. North Av., City 1

25a. REC'D BY REGISTRAR DATE: NOV 17 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15143

CERTIFICATE OF DEATH

15141

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater 02.1
d. STREET ADDRESS: Rt. 3, Box 293
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: A. — Last: TUCKERMAN

4. DATE OF DEATH: Month: November — Day: 9 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 4, 1887

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retail Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Hardware

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Alexander Tuckerman

14. MOTHER'S MAIDEN NAME: Minerva Yunkes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Lyda L. Tuckerman — Address: # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Carcinoma prostate
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
177X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1965, to 11-9-, 1966 that (I) (we) last saw the deceased alive on 11-8 1966, and that death occurred at 3:00 A.M. M, from causes and on the date stated above.

22a. SIGNATURE: Emily H. Wilson — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/9/66

22c. PHYSICIAN'S NAME (Type): Emily H. Wilson, M.D.

22d. ADDRESS: LOTHIAN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-11-1966

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven

23d. LOCATION (City or Town) (County) (State): Glen Burnie Md.

24. FUNERAL DIRECTOR: John M. Taylor + Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: NOV 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15144 15142

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A. A. General Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 0221
d. STREET ADDRESS: 99 East St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First James — Middle A. — Last Vaughan, Sr.

4. DATE OF DEATH: Month 11 — Day 9 — Year 1966

5. SEX: M

6. COLOR OR RACE: Col.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-27-1913

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Naval Acad.

11. BIRTHPLACE (State or foreign country): Henderson, N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Vaughan

14. MOTHER'S MAIDEN NAME: Josephine Kearney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 212-18-3996

17. INFORMANT: Henrietta Vaughan — Address: 540 Eastern Ave. Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
4344
INTERVAL BETWEEN ONSET AND DEATH: Instt.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

EXAMINER'S NAME (Type): F. L. Nyhoff

Address (Street, city, town, or county):

22. DATE SIGNED: 11-9-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/14/66

23c. NAME OF CEMETERY OR CREMATORY: St. Marys

23d. LOCATION (City, town or county) (State): Annapolis, Md.

24. FUNERAL DIRECTOR: William Reese, II — ADDRESS: Annp. Md.

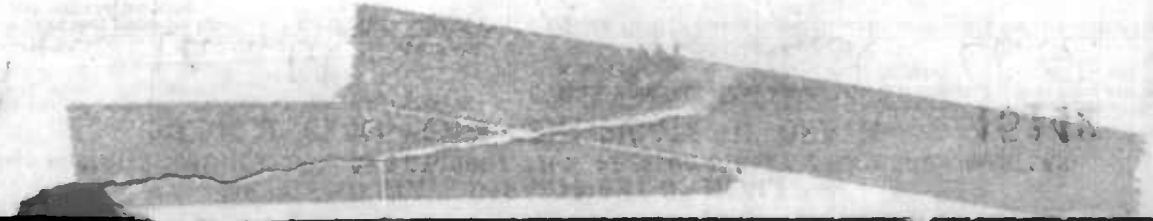
25a. REC'D BY REGISTRAR DATE: NOV 14 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME
3500 4-64



1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15145

CERTIFICATE OF DEATH

15143

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanover
d. STREET ADDRESS: 312 Simms Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert — Middle: L. — Last: Walker

4. DATE OF DEATH: Month: November — Day: 15 — Year: 1966

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 11-7-28

9. AGE (In years last birthday): 38 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: David F. Walker

14. MOTHER'S MAIDEN NAME: Lillian Mae Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service): ----------

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: Leroy Walker - Hannover, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 331X
DUE TO (b): Intracerebral Hemorrhage
DUE TO (c): Left Hemisphere
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/15, 1966, to 11/15, 1966, that (I) (we) last saw the deceased alive on 11/15 1966, and that death occurred at 5:40 M, from causes and on the date stated above.

22a. SIGNATURE: J. B. RAMIREZ — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/15/66

22c. PHYSICIAN'S NAME (Type): J. B. Ramirez M.D.

22d. ADDRESS: 3967 Annapolis Rd - 2 mi 2? Office — 1672 North Bonnie Rd 2 mi 2

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/ 18/66

23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cemetery

23d. LOCATION (City or Town) (County) (State): Fort Meyers, Va.

24. FUNERAL DIRECTOR: Robert Rivare — ADDRESS: Singleton Funeral Home/Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: NOV 21 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15146

CERTIFICATE OF DEATH

15144

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 3 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Annearundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Balto. #25 (Brklyn Park) 021
d. STREET ADDRESS: Holy Cross Rd. + Main Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jane — Middle: D. — Last: Walker.

4. DATE OF DEATH: Month: November — Day: 2, — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 15, 1915

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian

10b. KIND OF BUSINESS OR INDUSTRY: A.A.Co.Bd. of Ed.

11. BIRTHPLACE (County & State, or foreign country): Millersville Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Knott

14. MOTHER'S MAIDEN NAME: Jamey Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ———

16. SOCIAL SECURITY NO.: 214-30-3647

17. INFORMANT: Mrs. Betty L. Chisolm (daughter) Address: 3807 Pascal Ave. Balto. #25, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: hr.
DUE TO (b): Pulmonary infarctum with thrombosis
DUE TO (c): Paroxysmal atrial tachycardia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4331

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/13, 196[illegible] to 11/2, 1966, that (I) (we) last saw the deceased alive on 11/2 1966, and that death occurred at 2:01 P.M., from causes and on the date stated above.

22a. SIGNATURE: Williams A- [illegible] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/2/66

22c. PHYSICIAN'S NAME (Type): G. Linsao

22d. ADDRESS: North Arundel Hosp., Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 7, 1966

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.

23d. LOCATION (City or Town) (County) (State): Brooklyn, R.F.D., Maryland

24. FUNERAL DIRECTOR: R.V. Singleton — ADDRESS: Singleton Funeral Home (Glen Burnie) Md.

25a. REC'D BY REGISTRAR DATE: NOV 7 1966

25b. REGISTRAR'S SIGNATURE: Edward Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

7 1

FOR STATE HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15147

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15145

1. **PLACE OF DEATH**
   a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NORTH ARUNDEL GENERAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
   d. STREET ADDRESS: Camp Meade Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First WOODSIDE — Middle E. — Last WARFIELD

4. **DATE OF DEATH**: Month 11 — Day 28 — Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 19 Jan. 1902

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Gov't

11. BIRTHPLACE (State or foreign country): Anne Arundel Co., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin Warfield

14. MOTHER'S MAIDEN NAME: Ida Durm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address: Mrs Dorothy T. Warfield, same as 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic and hypertensive cardiovascular — 443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): disease
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: 11-29-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2 Dec. 1966

23c. NAME OF CEMETERY OR CREMATORY: Friendship Cemetery

23d. LOCATION (City or Town) (County) (State): Linthicum, Md.

24. FUNERAL DIRECTOR ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: DEC 1 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15148 15146

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie 02.1
d. STREET ADDRESS: 106 Phelps Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie Middle: May Last: Watts
4. DATE OF DEATH: Month: 10 November Day: Year: 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2 May 1881
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Marietta, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: August Weaver
14. MOTHER'S MAIDEN NAME: Carrie Zink

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 212-16-3720 D
17. INFORMANT Address: Mrs. Helen Namuth, same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 8, 1963 to Nov. 10, 1966, that (I) (we) last saw the deceased alive on Nov. 8, 1966, and that death occurred at 5.30 M, from the causes and on the date stated above.

22a. SIGNATURE: Edmond I. Moushabek M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Edmond I Moushabek, M. D.
22d. ADDRESS: 510 Marley Station Road, Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 14 Nov. 66
23c. NAME OF CEMETERY OR CREMATORY: Lorraine Park
23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE: NOV 15 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15149

CERTIFICATE OF DEATH

15147

1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL MARYLAND
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) EPPING FOREST
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street oddress) EPPING WAY

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE MD. b. COUNTY A.A.Co.
c. CITY OR TOWN (If outside carporate limits, write RURAL ond give nearest tawn) EPPING FOREST
d. STREET ADDRESS EPPING WAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ROBERT Middle G. Last WATTS SR.
4. DATE OF DEATH Month NOV Day 18 Year 1966
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2-23-1896
9. AGE (In yeors last birthday) 70 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER
10b. KIND OF BUSINESS OR INDUSTRY R.R. ENGINEER
11. BIRTHPLACE (County & State, or foreign country) CHAMBERSBURG Pa.
12. CITIZEN OF WHAT COUNTRY? U.S
13. FATHER'S NAME CHARLES B. WATTS
14. MOTHER'S MAIDEN NAME JENNIE GETTIN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address NELL M. WATTS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INANITION — INTERVAL BETWEEN ONSET AND DEATH 2 WKS
334X
DUE TO (b) CEREBRAL ARTERIOSCLEROSIS — 5 YRS
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factary, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JUNE, 1956, to LSNOV, 1966, that (I) (we) last saw the deceased alive on 11 NOV 1966, and thot death occurred at 2A M, from couses ond an the dote stated above.

22a. SIGNATURE Edward L. Beck M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 11/18/66
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 11-21-66
23c. NAME OF CEMETERY OR CREMATORY NORLAND
23d. LOCATION (City or Town) (County) (State) CHAMBERSBURG Pa.
24. FUNERAL DIRECTOR John M. Taylor & Sons ADDRESS Annapolis, Md.
25a. REC'D BY REGISTRAR DATE NOV 21 1966
25b. REGISTRAR'S SIGNATURE J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15150

CERTIFICATE OF DEATH

15148

1. PLACE OF DEATH
o. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): MILLERSVILLE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): KNOLLWOOD NURSING HOME

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
o. STATE: MARYLAND — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): DAVIDSONVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First CHARLES — Middle ST. CLAIR — Lost WAYSON SR.
4. DATE OF DEATH: Month NOV — Doy 5 — Year 1966
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: NOV 30 1878
9. AGE (In yeors last birthdoy) 87 yrs.
IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARM
10b. KIND OF BUSINESS OR INDUSTRY: FARM
11. BIRTHPLACE (County & Stote, or foreign country): McKINDREE MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LOUIS PRESTON WAYSON
14. MOTHER'S MAIDEN NAME: ELIZABETH SIMMONS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS. W. N. BRASHEARS — Address 16 EASTERN AVE ANNAPOLIS MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Acute myocardial infarction
DUE TO (b): Coronary occlusion
DUE TO (c): Arteriosclerotic Cardiovascular disease
Conditions, if ony, which gave rise to immediote couse (o), stoting the underlying couse lost.
INTERVAL BETWEEN ONSET AND DEATH: few hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (this haspital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from couses ond on the date stated above.

22o. SIGNATURE: R. M. Smith
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7 Nov, 1966
22c. PHYSICIAN'S NAME (Type): R. M. SMITH
22d. ADDRESS: HAHN Bldg. SEVERNA PARK, MD.

23o. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11-8-66
23c. NAME OF CEMETERY OR CREMATORY: ALL HALLOWS CHAPEL
23d. LOCATION (City or Town) (County) (Stote): DAVIDSONVILLE MD.

24. FUNERAL DIRECTOR: JOHN M. TAYLOR, SON — ADDRESS: ANNAPOLIS MD
25o. REC'D BY REGISTRAR — DATE NOV 10 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then pleose remove corbon papers. Pages 1 and 2 should be filed with the Stote Dept. of Health prior to buriol, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15151

CERTIFICATE OF DEATH

15149

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Severna Park
c. LENGTH OF STAY IN 1b: 36 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A Anne Arundel Gen Hosp

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A.A.Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Severna Park, Md
d. STREET ADDRESS: Whites Road Box 340A Rt1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Bernice	Delores	White	Nov	10	19 66

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Negro		2-20-1902	64 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	********	A.A.Co.Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob Pulley	Cynthia ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	*****	None	James Albert White	Severna, Park Rt1Box 340A

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocordial Infarction — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): M C V D
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1956, 19__, to __, 19__, that (I) (we) last saw the deceased alive on May 19 66, and that death occurred at 11:30 PM, from the causes and on the date stated above.

22a. SIGNATURE: Robert R. Hahn — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 11-10-66

22c. PHYSICIAN'S NAME (Type): Robert R. Hahn — 22d. ADDRESS: P.O.Box 73 Severna Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	11/13/66	Mt Calvary	Arnold A.A.Co.Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C.E.Hicks,lll	Annapolis,Md	NOV 16 1966	Charles Judge

VR A15 (4)
20M 1/65

X 1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15152

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15150

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1654 Delano Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

30-4

54

3. NAME OF DECEASED (Type or print): First CATHRYN — Middle O. — Last WILLIAMS

4. DATE OF DEATH: Month November — Day 4 — Year 19 66

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 20, 1950

9. AGE (In years last birthday): 16 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Oscar Williams

14. MOTHER'S MAIDEN NAME: Sarah Seaberry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Oscar Williams — Address: 3200 Burleith Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Spinal Cord Compression — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Fracture of Cervical Vertebrae.
DUE TO
(c):

8164

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Passenger in auto-auto collision.

20c. TIME OF INJURY Month, Day, Year: Hour 2:15 p.m. 11/4 19 66

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Beltway

20f. (City or town) (County) (State): Anne Arundel Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

22. DATE SIGNED: 11/4/66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-8-66

23c. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park

23d. LOCATION (City or Town) (County) (State): Arbutus Md.

24. FUNERAL DIRECTOR: Morton & Dyett F.H. — ADDRESS: 1701 Laurens Street

25a. REC'D BY REGISTRAR DATE: NOV 7 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 12 Film G383 12/5/66 mh

15153

CERTIFICATE OF DEATH

15151

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give neorest town): Watergate- Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1507 Gordon Cove Drive

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Watergate - Annapolis 02.1
d. STREET ADDRESS: 1507 Gordon Cove Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle Lost WILLIAMS,Sr.
4. DATE OF DEATH: Month Nov. Day 25 Year 1966
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Apr.28,1884
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker - ret.
10b. KIND OF BUSINESS OR INDUSTRY: self-employed
11. BIRTHPLACE (County & State, or foreign country): Denmark
12. CITIZEN OF WHAT COUNTRY? Denmark

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give wor or dates of service): WW I
16. SOCIAL SECURITY NO.: none
17. INFORMANT: son-John Williams,Jr. Address: 38 Monroe Ct., Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 177X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Heart Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, affice bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 10/17, 1963, to 11/25, 1966, that (I) ~~(we)~~ last saw the deceased alive on 6/23 1966, and that death accurred at 10A M, fram causes and on the date stated above.

22a. SIGNATURE: Richard L. Hochman — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/26/66
22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, M.D.
22d. ADDRESS: 59 Franklin St, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov.28,1966
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
23d. LOCATION (City or Town) (County) (State): Annapolis A.A. Md.

24. FUNERAL DIRECTOR: Beverley E. Hopping — ADDRESS: Beverley E. Hopping
HOPPING FUNERAL HOME - Annapolis, Md.

25a. REC'D BY REGISTRAR DATE NOV 30 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be filed with the State Dept. af Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15154 (15152)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Anne Arundel b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn): Laurel c. LENGTH OF STAY IN 1b: 7 yrs. 11 mos d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Children's Center Hospital	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C. 47.3 d. STREET ADDRESS: Crippled Children's Hospital e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First Richard; Middle Patrick; Last Young	4. DATE OF DEATH: Month Nov. Day 25 Year 1966
5. SEX: Male 6. COLOR OR RACE: White 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH: 1-16-56 9. AGE (In years last birthday): 9 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Institutionalized 10b. KIND OF BUSINESS OR INDUSTRY: --------- 11. BIRTHPLACE (County & State, or foreign country): Washington, D. C. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Unknown 14. MOTHER'S MAIDEN NAME: Edythe Barbara Young	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address: Children's Center Hospital, Laurel, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration (vomitus) — INTERVAL BETWEEN ONSET AND DEATH: 11/25/66
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Mental retardation - severe
DUE TO
(c): Athetoid quadiplegia

352X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 15, 1959, to Nov. 25, 1966, that (I) (we) last saw the deceased alive an Nov. 25, 1966, and that death occurred at 7:25 P.M., from causes and on the date stated above.

22a. SIGNATURE: James E. Boyland M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Nov. 28, 1966
22c. PHYSICIAN'S NAME (Type): JAMES E. BOYLAND, M. D.
22d. ADDRESS: Children's Center, Laurel, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
	Nov. 30, 1966	Children's Center	Laurel	A. A.	Md.

24. FUNERAL DIRECTOR: DeWitt Donaldson — ADDRESS: Laurel, Md
25a. REC'D BY REGISTRAR DATE: DEC 6 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge